



David Schmidt D.D.S.

General & Cosmetic Dentistry

FINANCIAL POLICY & CREDIT CARD AUTHORIZATION FORM

For all patients:

- Payment is due at the time services are rendered unless alternate arrangements have been made in advance.
- We require an initial deposit (min 50% of estimated copay) for treatment involving a laboratory such as crowns, bridges, occlusal guards, dentures and implants.

For patients with dental insurance:

- Dental insurance may only pay a portion of your cost and your portion is due no later than the time of treatment.
- If the insurance company pays less than estimated or denies your claim, you will receive a statement and it will be your responsibility to pay the difference. If the insurance company pays more than estimated, you will be sent a refund for the difference.
- If your insurance payments are sent directly to you instead of Dr Schmidt, you are responsible for providing payment to the office at the time of service. We will file an insurance claim on your behalf for your reimbursement.
- If your insurance provider does not respond to submitted claims within 45 days, you will assume immediate responsibility for the payment and pay the balance owed in full.

For your convenience, we can add you credit card on file with us for unpaid balances.

When charges are processed, we will send you a courtesy notification by text or email.

Patient Name: _____ Cardholder Name: _____ Relationship: _____

Billing Address: _____

Card Number: _____ Exp date: ____/____ Sec(CVV) Code: ____

Is this an employer Health Savings or Flexible Spending card?: _____ YES/_____ NO

Should this card be used for other family members?: _____ YES/_____ NO

List family member names with DOB: _____

_____ **I prefer not to leave credit card authorization on file.** I understand that all payments and copayments must be made at the time of treatment.

Patient (print name): _____

Responsible Party (print name): _____

Responsible Party (signature): _____ Date: _____