Spouse or Responsible Party Information

The following is for: □ the patient's spouse □ the person responsible for payment

Name: _____

□ Male □ Female □ Married □ Single □ Child □ Other _____

Social Security #: _____ Birth Date: _____

Home Phone: _____Work Phone: _____Ext: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____**Insured's Birth Date**: _____

Phone # of Insured: _____**Insured's Social Security** #: _____ **Relationship to patient**:_____

Insured's Address:_____

Insured's Employer:_____

Insurance Plan Name and Address:_____

_____

Insurance Phone #: _____**Insurance Group #:** _____

Secondary

Name of Insured: _____Insured's Birth Date: _____

Phone# of Insured: _____Insured's Social Security #: _____Relationship to Patient: _____

Insured's Address: _____

Insured's Employer and Address: _____

Insurance Plan Name and Address: _____

_____

Insurance Phone #: _____Insurance Group#: _____

Consent For Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will file the claims to the insurance companies and help with phone calls to them when necessary. All quotes given from insurance companies are just estimates and are NEVER a guarantee of payment. This office will send pre-estimates to the insurance companies if requested by patient. Patient's estimated co-pay will be due at the date of service unless other arrangements have been made. Any claim not paid within 45 days of the date of service will then be the patient's responsibility. The balance not paid by the insurance will be due by the patient.

----I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

----I grant my permission to you or you assignee, to telephone me at home or at my work to discuss matters related to this form.

----I understand that I am completely responsible for the payment of all expenses incurred. I assign and authorize Finley Periodontics, P.L.L.C. payment of any and all benefits payable by Insurance and the necessary release of medical information needed to process all insurance claims. In the event of non-payment I agree to bear the cost of collection and/or court costs and reasonable legal fees not to exceed 50% of the unpaid balance. The undersigned waives rights of exemption under the state of Louisiana. Payment is required at the time of Service!

I hereby authorize any treatment deemed necessary by James M. Finley, D.M.D., M.S.

_____ _____

(Patient Signature/ Responsible Party) (Date)