508 Indiana Avenue
Indianapolis, IN 46202
(317) 269-0402
Fax: (317) 269-0405
Email: info@sonrisadental.com

Name:____
SS#_______________D.O.B._________________SEX______

All professional services are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. ***THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.***

AUTHORIZATION AND ASSIGNMENT (Please read and sign).

I hereby authorize Sonrisa – A Periodental Spa to furnish information to insurance carriers concerning my illness or injury and treatments and I hereby assign to the dentists all payments for dental services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

In consideration of services rendered, or to be rendered, I agree to pay all accumulated charges not covered by insurance, including an additional 1.5% late charge (18% APR) in the event that payments are not received by agreed upon dates. In the event of default on said payment, I hereby agree that reasonable attorney fees for collection of the above amount may be added.

Signature:_______________________________________
Date:_____________

Would you be interested in using any of our extended payment options?
Yes_________ No__________

patientfin.doc