FINANCIAL AGREEMENT FOR SKYVIEW RANCH DENTAL CLINIC

We offer two different options in which your dental treatment can be paid. Please choose one of the following options.

Option One- You may pay full at the time of service; after which we will submit your dental claim on your behalf and inform the insurance company to issue the cheque directly to you.

Option Two- Direct billing from Skyview Ranch Dental Clinic asking the insurance to issue the cheque directly to the dental office. Assignment of benefits from your insurance company will require a valid **VISA OR MASTERCARD** to be left on file. Our office will not allow any balances to extend past 45 days from date of service.

All dental procedures in our practice are treatment planned based on the dental needs of the individual patient; not limited to the benefits extended by their insurance providers. Neither the dental office nor its employees will assume responsibility of knowing dental coverage details.

Credit Card Authorization

I authorize Skyview Ranch Dental Clinic to keep my signature and card information on file* and to charge my **VISA OR MASTERCARD** account for the following (**please initial next to the following four points);**

_____ Balances of charges not paid by my insurance immediately after receiving payment from the insurance company. Individual phone calls from the office will **NOT** be made before the card is charged for expenses, unless the amount should **exceed $200.00**. A receipt and any explanation of benefits available will be sent to your home.

_____ All outstanding balances on my family account if not paid within 45 days by my insurance.

_____ Charges accrued as a result of broken appointments or short notice cancellations within reason. This fee is $75.00 per individual for each failed appointment.

_____ This authorization will be held for each client listed below until otherwise notified to our office in writing stating otherwise.

Patient Name(s):_____

PLEASE WRITE DOWN THE NAMES OF ALL FAMILY MEMBERS AUTHORIZED FOR THIS CREDIT CARD

Cardholder Name: _____

Cardholder Address: _____

City: _____ Postal Code: _____

Phone Number: (H)_____ (W)_____ (C)_____

Account Number: _____ Expiry Date: _____

Verification Code:_____(last 3 digits on back of card)

Cardholder Signature:_____

***All information obtained and held by Skyview Ranch Dental Clinic is protected under the privacy act. Each team member is held within the same laws as the clinic and will respect all aspects of the privacy act on your behalf.**

***Each agreement will be scanned into the office manager's computer only. The hard copy will be carefully disposed of through Iron Mountain; a company employed through Skyview Ranch Dental Clinic for shredding purposes, which is also held within the same laws as Skyview Ranch Dental Clinic.**