

# ADVANTAGE DENTAL CARE

**Dr. George Harouni**

## FINANCIAL INFORMATION:

Thank you for choosing Advantage Dental Care as your Dental Provider. It is our goal to provide the finest dentistry and best care possible.

## INSURANCE:

As a courtesy, we will bill your insurance company for covered charges. In order to bill your insurance you will need to provide us with the necessary accurate and complete information. Remember that your insurance policy is a contract between you and your insurance company and you are responsible for all charges incurred. We expect insurance payment within 45 days from the date of service. If your insurance has not paid and the account becomes 60 days old, the account may become a cash account and may be due and payable at that time.

## WE HAVE MANY PAYMENT OPTIONS AVAILABLE:

Cash/Personal Checks/All Major Credit Cards and Outside Financing  
I hereby guarantee payment of all charges incurred for the account of the above mentioned. I realize that insurance may not cover the amount charged and that I will be responsible for the balance left after insurance. I understand that balances not paid timely are subject to additional charges and or collection procedures.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

## DENTAL CONSENT:

I have completed a health history, and have reviewed past and present medical conditions with the dentist. Anticipated dental treatment will be discussed with me in person and any changes to the plan will be made known to me.

My authorization for dental treatment is given for:

\_\_\_\_\_ Complete Dental Evaluation  
\_\_\_\_\_ Dental Radiographs (X-rays)  
\_\_\_\_\_ Dental Cleaning

PATIENT NAME: \_\_\_\_\_

If there is no insurance coverage available, I understand that I am responsible for all charges incurred t the time of service.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Guardian/Parent)

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_  
(Doctor)