SRQ ENDODONTICS FINANCIAL AGREEMENT

We are happy to process any insurance claim as a service to you. Your dental plan is designed to share in your dental care costs and it may not cover the total cost of your bill.
We ask that you pay your portion of the fee at time of service and require that you guarantee the balance of charges not paid by your insurance with a credit card. If you choose to not leave a credit card on file, payment will be expected in full at the time of service.

This document represents a financial agreement between the undersigned and
Raul A. Ortiz DMD, PA.

PATIENT NAME _____

CREDIT CARD INFORMATION:
VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS

Name on card: _____

Account #: _____

Expiration Date: _____CVC code_____(on back of most cards)

Any account balance after your insurance payment is received will be processed.
When we receive payment with an explanation of benefits from your insurance company we will run your credit card for the balance then mail a receipt to you.
This payment will be made with the credit card listed above and if the result is a credit balance we will mail you a check.
If we are unable to run your credit card you will be contacted by a member of the staff.
If the account is turned over to a collection agency a 20% collection fee will be added to your account.

X _____
Patient/ Responsible party Date