Faith W. Trent, D.D.S., P.C.

Insurance & Financial Responsibility Form

Patient's Name_____ Home Phone _____
Employer _____ Work Phone _____

CONTACT INFORMATION:

Email _____
Cell _____

Guarantor's Information/Policy Holder

Dental Insurance Name_____Grp #_____
Policy Holder's Name_____
Policy Holder's Social Security #_____Date of Birth_____
Address_____ Home Phone_____
_____ Cell Phone_____
Employer_____ Work Phone_____

In case of emergency, call_____Phone_____
Relationship to patient_____
Referred By_____

Agreement

1. Payment is due at the time of service.
2. For patients with dental insurance, all co-payments and deductibles are due at the time of service.
3. Any other payment arrangement must be made prior to dental work being completed and agreed upon by this office.
4. I understand that I will be charged a minimum of $36.00 for missed or canceled appointments unless 24 business hours notice is given.

I hereby authorize Faith W. Trent, D.D.S. to render all dental services to myself (or child) and to release any information regarding my medical/dental history, diagnosis and treatment of myself (or child) to my insurance company regarding claim benefits. I authorize payment of dental benefits to Dr. Trent. I understand and agree that insurance benefits are an arrangement between my insurance company and myself. As a courtesy to me, my insurance company will be billed; however, the entire balance remains my responsibility (or the above patient, if applicable). I understand that payment in full is due within thirty (30) days after the first billing. In addition, I agree to pay a FINANCE CHARGE of 1.5% per month on balances over ninety (90) days past due, which is an ANNUAL PERCENTAGE RATE of 18%. If my account is referred to an attorney for collection, I agree to pay all court costs, including attorney's fees in the amount of thirty-three and one-third percent (33-1/3%) of the total indebtedness then due.

Signature_____**Date**_____

Relationship to Patient: Self / Spouse / Parent / Legal Guardian / Other:_____