



HEATHERWOOD DENTAL

13619 NORTH 59TH AVENUE

GLENDALE AZ 85304

602-938-2911 602-938-5735 fax

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize Heatherwood Dental to release any information including the diagnosis, radiographs, and treatment notes rendered me during the period of such medical/dental care to third party payers (insurance) and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to Heatherwood Dental insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services rendered on my behalf, or the behalf of my dependents.

If I do not pay the entire balance within 90 days of the monthly billing date, a billing fee of 1.5% per month will be charged on the balance owed. I realize that failure to keep this account current will result in Heatherwood Dental being unable to provide additional medical/dental services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balance.

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have questions concerning financial arrangements or need special arrangements, please ask for assistance.

_____Cash_____Personal Check_____Credit Card

Signature of Patient, or Parent/Guardian if Minor Date

* * * PLEASE NOTE * * *

As a courtesy to you, we will file insurance on your behalf and ESTIMATE your portion that is due and payable at the time of service. It is your responsibility to provide us with correct, current insurance information and see that your insurance company pays in a timely manner.