Healthy Smile Center

9 N Washington
Oxford, MI 48371
(248) 969-4840 / Fax (248) 969-4841
www.hsmile.com

PAYMENT POLICY AND INSURANCE INFORMATION

Patient name _____

Who is responsible for this account _____

Relationship to patient _____

Social Security number _____ **Birthdate** _____

Insurance Company _____ **Group#** _____

- **Assignment and release**

I certify that I, and/or my dependent(s), have insurance coverage with

Ins. Company **Employer:**

- **And assign directly to Dr. Martha Vega-Crist DDS all insurance benefits. I understand that I am responsible for all charges whether or not paid by the insurance company. I authorize the use of my signature on all insurance submissions.**
- **The above-named doctor may use my health care information and may disclose such information to the above-named insurance company, and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.**

Please understand that it your responsibility to know your individual Insurance coverage. If your insurance does not cover our services you are responsible for full payment at the time services are rendered. A co-payment is also due at time services are rendered.

A monthly credit fee of 1.5% will be applied to any unpaid portion of your balance that remains unpaid after 30 days. In addition, if your insurance does not pay us within 60 days, it is your responsibility to contact your insurance company and/or pay the balance in full.

CANCELLATION NOTICE

A 24-hour notice is required for cancellations or there will be a charge of $40.00 to your account.

Patient Signature_____**Date**_____