Delaine Anthony, D.M.D, P.C..
2181 E. Warner Rd. #104
Tempe, AZ 85284
480-812-8088

FINANCIAL POLICY

Thank you for choosing our office for your Dental needs. We will make every effort to make your visits as pleasant and stress-free as possible.

With your cooperation your financial needs will also be met in the same fashion. Payments are accepted by cash, check, or Visa/Mastercard and Discover. We also offer financial arrangements for patients who need extensive treatment. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 90 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies or when there is prepayment for additional services.

Our office requests 24-hour advance notice for a missed appointment. We understand that this is not always possible. However, upon a patient missing an appointment without sufficient notice or cause, a forty five dollar ($45) fee will be added to their account. Subsequent appointments will not be made until a patient's balance is cleared.

As a courtesy to you, we will fill out and submit your insurance forms for payment. We do ask that you pay any deductible that applies and your portion of the charges not covered by your insurance unless other arrangements have been made.

Please do not hesitate to call us for any reason if we can be of assistance to you. Thank you.

The Staff of Dr. Anthony's Office.

AUTHORIZATION

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____