ROSEWOOD
DENTAL, PLC

Responsible Party Name_____
Last First Middle Marital Status

Residence_____
And Street City State Zip

Mailing address_____
Street City State Zip

How long at this address_____Home Phone_____Work Phone_____

Name you prefer to be called: _____ Email address_____

Alternate Phone _____ Social Security #_____Birth Date_____

Employer_____ Occupation_____ No. Years Employed _____

If Dental Benefits through this employer:

Policy Holder's ID # _____ Insurance Company Name_____

Group Number/Name _____ Address for Dental Claims _____

Effective Date of Policy _____ Insurance Company Phone #_____

List Patients Covered under this Policy: _____

Spouse's Name_____
Last First Middle

Preferred Name: _____ Email address_____ Work Phone_____

Alternate Phone_____ Social Security #_____ Birth Date_____

Employer_____ Occupation_____ No. Years Employed _____

If Dental Benefits through this employer:

Policy Holder's ID # _____ Insurance Company Name_____

Group Number/Name _____ Address for Dental Claims _____

Effective Date of Policy _____ Insurance Company Phone #_____

List Patients Covered under this Policy: _____

Note any patients with double coverage & order of coordination here:

Release and Assignment for Benefits

I hereby authorize the release of any information including the diagnosis, and records related to any treatments and/or examinations, to the insurance company or companies above. This release is solely for the purpose of facilitating insurance, billing, and reimbursement.

Signed_____ _____ Date_____

Rosewood Dental, PLC Financial Policy

Please carefully read these payment options and select the appropriate one:

□ I choose to **pay in full by cash, check, or debit/credit card on the day that treatment is rendered**. This is the only option for procedures to which there are no dental benefits applied (no insurance) and when no other arrangement has been made prior to the appointment time. This option also applies to situations where the insurance will not pay directly to the dental office (e.g. BCBS). If you select this option and have dental insurance, any benefit payments will go directly to the insurance policy holder.

□ I have a dental insurance plan which pays directly to my Rosewood Dental, PLC account. I will pay my portion, also called the estimated **out-of-pocket, in full at the time of service**. If your insurance company happens to send their portion directly to you, you agree to sign the check over to Rosewood Dental, PLC within 10 days of receipt.

□ I have already arranged for special financing through CareCredit.

Care Credit Account #__ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Credit Limit $_____

____ Check here if you are interested in learning more about possible monthly payments through Care Credit.

Please read the disclosures below. "We" means Rosewood Dental, PLC, and "you" and "your" refers to the responsible party.

There will be no charge for appointments broken with 48 hours notice.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at a rate of one and three quarters percent (1.75%) per month or an **ANNUAL PERCENTAGE RATE** of twenty-one (21%) percent.

Dental Insurance: We offer the service of helping you file claims for dental benefits. Dental benefits come from a contract between you or your employer and your benefit company. We are not a party in this contract. While we may have access to some of your contract information, it is your responsibility to know your benefits. If you have questions about your dental benefits, contact your company or employer.

Credit History: You give us permission to check your credit, including any that Care Credit will disclose, and employment history and to answer questions about your credit experience with us. This options is generally only exercised when preparing financing or actively collecting past due accounts. We have the option to report your account status to any credit-reporting agency such as a credit bureau.

Past Due Accounts: If your account becomes past due, we will take steps to collect your balance. If it becomes necessary, we will refer your account to a collection agency or local court. You agree to pay all of the collection costs that are incurred, including court costs and attorney fees.

Waiver of Confidentiality: You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

I have read the disclosures above and agree to pay for all services that are received at Rosewood Dental, PLC.

_____

Signature of Responsible Party Date

_____

Co-Signature/Other Responsible Party Date

Please list any other Patients covered by this signed financial policy:

_____Relationship to Responsible Party_____

_____Relationship to Responsible Party_____

Please tell us how you heard about Rosewood Dental._____

If you know someone who would like more information about Rosewood Dental, please ask for a referral card or have them visit www.rosewooddentistry.com. Thank you!