Direct Billing Patient Agreement Form

- Due to the Canadian Personal Privacy Act we are unable to access any specific information from your dental insurance company regarding your coverage. I understand my dental insurance policy may have a yearly dollar maximum, fee guide limitations or other restrictions, etc.
    - Initial _____
- Dangstorp Dental accepts no responsibility for any uncovered amount, amounts over benefit maximums, plan limitations or restrictions etc.
    - Initial _____
- The amount not covered by my insurance is due the day of treatment if the break down is know. If an insurance breakdown is not available at the time of the appointment and no insurance payment is received within 30 days the full amount will be processed on your credit card to set your outstanding balance to zero.
    - Initial _____

I agree to the Financial Responsibility for the following:

The Out of Pocket Portion and Balance not covered by Insurance

I,_____ authorize Dangstorp Dental to keep my signature on file and to issue a transactions to my credit card for any under payment once my insurance portion has been received. I will be notified by phone or mail of any charge or credit that exceeds $200.00. I give my permission for any amount not paid by my insurance within 30 days, to be automatically put through on my credit card. A receipt for this transaction will be mailed with a paid statement.

Signature:_____ Date:_____
E-mail address:_____

- Visa
- MasterCard

Name on Card :
Credit Card Number:
Expiry Date:
CVC:
Signature: