PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION.

Authorization and Release

If you have dental insurance, we will prepare and submit your dental claims as a courtesy to you.

Payment is due in full at the time of treatment.

I acknowledge that I am financially responsible for all changes whether or not they are covered by insurance. I hereby authorize payment directly to Seaside Dental Clinic of the group insurance benefits otherwise payable to me. I also authorize release of any information including this diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees.

Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month, or 18% annually or $5.00 rebilling fee whichever is greater. These additional fees will be applied to the unpaid balance at the end of the month.

Name *(Please print)*:_____

Signature: _____ **Date:** _____