CREDIT/DEBIT POLICY

PATIENT NAME ____________________________________

I understand it is the policy of Michelle Deutch, D.D.S. to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with the provisions of the U.S. law.

If, after a claim has been submitted to my insurance carrier: 1) the claim is denied for any reason: OR 2) there is a patient liability (I.E. Deductible, Co-insurance, etc.) the office will send a statement notifying me of the balance. If this amount is not paid within 60 days, then my credit or debit card will be charged for the entire balance owed for treatment of services to me.

I understand my insurance company will also provide notification of these charges with an explanation of benefits. In the event this amount exceeds $250.00, the office will provide a courtesy call to my phone number.

I understand that in the event my credit or debit card has been charged for treatment or services, and then my insurance carrier subsequently makes a payment to the office for those charges, the office will issue a credit to my credit or debit card.

PLEASE CIRCLE ONE OF THE FOLLOWING:

VISA, MC, AMERICAN EXPRESS, OR DISCOVER

CARD/ACCOUNT NUMBER ____

EXPIRATION DATE ________________________ Security Code ____________

NAME OF CARDHOLDER ___________________________________

I hearby authorize Michelle B Deutch, D.D.S. and its designated employees to charge my credit/debit card as designated above.

______________________________________ ___________________

Cardholder’s Signature Date