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FINANCIAL POLICY & CREDIT CARD AUTHORIZATION FORM

Thank you for choosing Omid Farahmand, DMD. Our primary mission is to deliver the best and most comprehensive dental care available. Our fees are based on the quality materials we use and the time, effort and skill required in performing your treatment. They are reasonable and customary to our area. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options. We accept cash, check, Visa, MasterCard, or Discover Card. For extensive cases/treatment we offer usage of a convenient Monthly Payment Option from CareCredit. Full payment is due at the time services are rendered unless alternate arrangements have been made in advance with the office manager. *For all patients with dental insurance, we require a credit card to be kept on file for any balances unpaid by the insurance.* Please note that insurance coverage provided is only an **ESTIMATE**, and **NOT A GUARANTEE OF PAYMENT**. While the filing of insurance claims is a courtesy that we extend to our patients, any fees not covered by your insurance are ultimately **PATIENT RESPONSIBILITY**, (or parent if a minor). Once we receive payment from your dental insurance carrier, if there is any balance remaining, we will charge the credit card on file. While most PPO dental insurances do directly reimburse the dentist, some may only remit payment to the patient. In this case, the patient is responsible for providing payment in full to the office and we will file a claim on your behalf to your carrier for reimbursement. Should any balance remain unpaid after 60 days or should you violate the terms of your payment agreement, we reserve the right to refer your account to our collection agency. Any fees associated with the collection of these delinquent accounts will be the direct responsibility of the patient. There will be a $30 fee for any returned checks.

Upon any credit card charges processed, please send me a courtesy notification by: (CHECK ONE) _____ Phone _____ E-Mail _____Mailed Receipt NOTE: We do not wait for a verbal, text or email approval, as this form serves as the authorization.

Patient Name: _____

Cardholder Name: _____ Relationship: _____

Credit Card Billing Address: _____

Credit Card #: _____ Exp Date: ____/_____ Sec Code: _____
Cardholder Signature: _____ Date: ____/____/_____

Should this card be used for all family members? _____YES _____NO