Parkinson Dentistry
10465 Gibsonton Drive
Riverview, FL 33578-5427

. . PATIENT FINANCIAL AGREEMENT

PATIENT:. . DOB:

As a courtesy to you, we can accept and file your dental insurance. Any outlined **estimate** given is based on limited information obtained from your insurance company and **is not a guarantee of payment**. When filing claims on your behalf, we allow **30** days for your insurance company to make a payment. After **30** days all inquires (follow-ups & appeals) on payments due will **become your responsibility**.

Please note: Insurance benefits are not verified before every appointment.

If there is any remaining balance after insurance claims are paid, a statement will be mailed to your address on file. If no payment is made we will use the the card on file to satisfy balance.

A $65/per hour CANCELLATION FEE WILL BE CHARGED IMMEDIATEY TO THE CARD ON FILE IF I OR A FAMILY MEMBER ON MY ACCOUNT FAILS TO SHOW FOR AN APPOINTMENT. THIS FEE WILL ALSO APPLY IF AN APPOINTMENT IS NOT RESCHEDULED OR CANCELLED WITH A 48 HOUR NOTICE
By signing below, I understand the terms and conditions of the above mentioned Financial Agreement and do hereby authorize PARKINSON DENTISTRY, PL to debit the account named above. If the card on file declines or is not valid your account will be immediately sent to a third party collections agency with up to an additional 40% in collection fees.

Credit Card on File: Visa M/C Discover Bank Acct Debit

Card Number:_____Exp. Date:_____CVV_____

Care Credit:

Card Number:_____Exp. Date:_____CVV_____

Fee For Service: (no insurance)_____

Signed:_____Witness:_____
Patient/Guardian Signature

Date:_____

Phone: (813) 677-7800 fax: (813) 677-6042

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