Charles B. Foy, Jr., DDS, MAGD
Financial Agreement

Patient's Name: _____
Person Responsible for Finances: _____

The following information to be completed by the responsible party as it applies to them:
Mailing Address: _____
City/State/Zip: _____
Home Phone #:_____ Work: _____ Cell: _____
Social Security # _____ Date of Birth _____
Employer: _____ Length of Employment _____

Primary Insurance Information
Policyholder's Name: _____ Relation to Patient _____
Address: _____
City/State/Zip: _____
Birth Date: ___/___/____ Social Security Number: _____
Employer: _____
Insurance Company_____ Group#: _____
Address: _____
City/State/Zip: _____

Payment Agreement

____ Payment in full *

____ Partial Payment Today * (eligible when filing insurance for the balance) - However, I understand that I am responsible for any unpaid amount which will be billed to a major credit card on file.

I will accept the offer from your office to file and accept payments from my insurance carrier as a courtesy to me. I understand that to receive this benefit, I will need to guarantee my account balance with my credit card. I understand that as soon as my insurance carrier issues a payment, or after ninety days, the unpaid portion of my claim will be charged to the credit card without any penalty from the dental office. I understand that if for some reason my credit card is not available for covering the treatment fee balance, then I am fully responsible for payment.

Credit Card # _____ Exp ____/_____
Visa ____ Mastercard ____ Discover ____ Amex ____ Care Credit ____
Billing Zip Code _____ V code (three numbers on back of card) _____

_____ _____
Patient/Responsible Party Signature Date

____ I need additional payment options *

Thank you for your trust and cooperation.

* All information is confidential and used for your account with this office only.