

HYATT FAMILY DENTAL

8711 Bedford-Eules Road

Hurst, TX 76053

817-589-0496

FINANCIAL POLICY

FINANCIAL ARRANGEMENTS

Payment must be made for treatments at the time the appointment is scheduled. Financial arrangements will be reviewed at treatment diagnosis and an opportunity to schedule will be given. If you are unable to make a financial arrangement at that time, you may make payment by phone when you call to schedule for treatment.

We accept cash, checks, American Express, Discover, MasterCard and VISA as well as Care Credit and Lending Club payments.

Care Credit and Lending Club payment options must be arranged prior to services scheduled.

To complete applications visit:

<http://www.CareCredit.com/Apply> OR <http://www.LendingClub.com/PatientSolutions>

As a courtesy, we offer to file dental claims with your dental benefit plan. In order to do this it is important for us to have the most current information to verify your benefit eligibility prior to your dental appointment.

We will be happy to accept assignment of benefits from you dental benefit plan, however we require a credit card on file in order to process remaining balance owed or refund transactions as of May 1, 2015.

All claims must be paid by your dental benefit provider within 30 days from the procedure date, otherwise the outstanding balance will be charged to your credit/debit card on file. Should payment by your dental benefit plan come later, to our office, we will apply a refund back to your credit/debit card on file.

AMERICAN EXPRESS

DISCOVER

MASTERCARD

VISA

ACCOUNT NUMBER: _ _ _ _ _

EXPIRATION DATE: __ / __

NAME ON CARD: _____

BILLING ADDRESS: _____

CITY/STATE/ZIP: _____

COLLECTION OF BALANCES DUE

An itemized paper statement will be mailed following reply from your dental benefits provider. Email and text messages will be sent to notify you of balance or refund applied to your credit card on file.

Should you have an in-active credit card number on file, we will notify you as listed above and call you to get updated credit card information.

Balances on account that exceed 45 days will be sent to our collections service. All future payment arrangements will be made to them directly. We hope to prevent this action from occurring by having updated information on file for you at the time services are completed.

Thank you for your cooperation in these matters. Please sign in the space below to confirm that you understand this information.

By signing below, you enable our office to extend the courtesy of filing your dental benefit claims (should this apply to you) and you hereby authorize Clinton Hyatt, D.D.S. to release information acquired in the course of dental care to your dental benefit company.

I hereby authorize benefits to be paid directly to Clinton Hyatt, D.D.S. when applicable.

I have read and understand the statements above.

PATIENT NAME (PRINTED) _____

PATIENT/GUARDIAN SIGNATURE _____ DATE ____ / ____ / ____

NAME OF POLICYHOLDER (PRINTED) _____

POLICYHOLDER SIGNATURE _____ DATE ____ / ____ / ____

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