FINANCIAL AGREEMENT PREAUTHORIZATION FORM

This form is to cover any fees that are not covered by your insurance company. Our office is a paperless office, so we do not send statements. We try to be diligent in estimating your portion upfront, but sometimes there are services that are denied, or the insurance company pays less than the estimated portion. This allows us to avoid sending a statement which includes a billing charge to you.

I authorize, J. Terry Frey, DDS to charge my credit or debit card as detailed below:

This signature will be kept on file to cover any unpaid balance after insurance payment for any treatment performed in this office.

Patient name: ____

Responsible party name: ____

Address: ____

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Work phone # ________________________

Home Phone #_____________________

Driver's license number: ____

CREDIT CARD

Visa **Mastercard** **Discover/Novus** **American Express**

Card #: ______________________________________ **Exp date:** __________

DEBIT CARD OR SECOND CREDIT CARD

Card #: ____ **Exp date:** __________

Cardholder signature: ____

Printed name: ____

Staff initals: __________ **Date:** __________________

Copy to patient, file in SmartDocs