INSURANCE EXPRESS CHECK OUT FORM

Patient Name: _____ **Date:** _____

PATIENT AGREEMENT

I agree to the FINANCIAL RESPONSIBILITY for the out of pocket portion and balance not covered by my insurance plan(s).

I, _____ authorize Royal Vista Dental Clinic to keep my signature on file and to issue a credit or debit memo to my credit card account for any over and under payment once my insurance portion has been received for dental treatment I received at Royal Vista Dental Clinic. I will be notified by phone or mail if any charge or credit is in excess of $200.00.

I give permission for any claim not paid by my insurance company within 45 days, to be automatically put through on my credit card. A receipt for this transaction will be mailed with a paid statement.

Signature: _____ Date: _____

Payment By: ☐ Visa ☐ Master Card ☐ American Express

Credit Card Number: _____ Exp Date: _____

Name on the card: _____

Signature: _____

I do not have a credit card, but I have permission for you to use a family member or spouse's card.

Relationship to this person: _____ Their phone #: _____

Credit card information provided above.

Please note patients are able to opt out of this Payment Agreement by providing Royal Vista Dental Clinic with a written request to do so.