Financial Arrangements for:

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Print Patient Name

PAYMENT CHOICES

( ) Cash or Check

( ) MasterCard or Visa. Pre-Authorized Healthcare Form signed: YES NO

( ) Outside Financing (CareCredit)

I understand that any account balance will have 1 ½% interest added each month on the billing date. This is 18% annual interest. To avoid this finance charge, any account balance must be paid in full promptly.

I hereby authorize Dr. Kelly to perform any or all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment full explanation of the procedure(s) and the fees involved will be given by the doctor and/or his staff.

I agree to pay for all services rendered by this office at time of service.

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Signature of Responsible Party Relationship Date

For patients who carry dental insurance: I am personally responsible for all charges.
I understand that Kelly Dental Care will submit all dental claims to my dental insurance company on my behalf. My dental insurance company will most likely send reimbursements directly to me personally. If reimbursement from my dental insurance company is sent to Kelly Dental Care, my account will be credited or I will be reimbursed by Kelly Dental Care.

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Signature of Responsible Party Relationship Date