SILVAGGIO ENDODONTICS
EASTON ENDODONTICS, LLC

For those patients who have dental insurance, as a ***courtesy to you***, rather than collecting full fees, we have contacted your dental insurance company for information on your insurance plan. We have ***estimated*** today's ***co-pay*** based on ***that*** information. This co-pay is ***not guaranteed*** . Once your claim is paid by your insurance company, any balance due is ***your*** legal responsibility, (the parent/guardian responsibility, if the patient is a minor).

Monthly billing charges of $3.00 will be incurred if your account is not settled within 60 days. Please note that if your account remains unpaid for a period of 60 DAYS, your account will be placed with the HAMILTON LAW GROUP, PC for collection. You will be responsible for interest of 1.5% per month (18% per year), and for collection attorney fees of 35% on the unpaid balance and interest.

Your ***co-pay due today*** is **$**_____. If you are ***unable to pay your co-pay today***, you ***must reschedule*** your appointment to a time that is financially convenient for you. ***My payment today will be paid with:***

VISA_____ MASTERCARD_____ DISCOVER_____ CARE CREDIT_____++

++***Per Care Credit****: The card must either be in* ***your own name*** *or you must be an* ***authorized signer*** *on the account.)*

CASH_____ CHECK_____

*****IMPORTANT NOTE: THERE IS A $35 FEE FOR RETURNED CHECKS.***

I, (print name)_____,
understand there is a return check fee. I also understand all of the above-mentioned information regarding my payment for today's visit and any balance that remains unpaid, including after my insurance benefits have paid according to my plan negotiated between my/our employer(s) and the insurance company(ies), or between me/us and the insurance company(ies).

SIGNATURE:_____ **DATE:**_____
If patient is a minor, Patient's Name_____
Relationship to Person Financially Responsible_____