

Natalie A. Lenser DDS

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Credit Card Financial Agreement Form

This letter is to finalize our financial agreement for uninsured services, Dental fees and late payments on your account. You agreed to an automatic credit charge on your Master Card, Visa, ATM-Check card, American Express or your Care Credit card to cover any balance due. Please sign this letter where indicated to confirm this agreement and return or fax to our office. (209) 571-7285 fax.

Date: _____

Name of Card Holder _____

Address _____

City, state, _____ **Zip** _____

Home Phone _____ Cell Phone _____

Patient Name: _____ Age _____

Amount of payment \$ _____

Card Number #: _____ Exp. Date _____/_____/_____

Security Code (on back of card) _____ Zip Code _____

____ Master Card ____ Visa ____ American Express ____ ATM-Check Card ____ Care Credit

Card Holder Signature

Date

Dental benefit plans may cover only part of your dental treatment. It is understood that you are responsible for the entire balance of your account. The Contract of dental benefits is between the patient and the insurance company. The fact that we do not write or administer your Dental Benefit plan makes it impossible for us to assure any payment from a third party carrier for any part of the estimated treatment plan. **You are responsible for all services rendered, regardless if you have dental benefits or not. We bill your insurance company for you as a courtesy.**