The DENTAL DESIGN Center

Ira J. Handschuh, DDS, PC

Patient Registration Form and Office Financial Arrangement Policy

Name________________ SS#________________ Date__________
Address________________ City________________ State__________ Zip Code______
Telephone________________ Work Telephone________________ e-mail__________
Occupation________________ Employer________________ Address__________

Person Financially Responsible for Account________________ Telephone__________

In an effort to provide you with quality care and to maintain our present fees by minimizing billing procedures.

PAYMENT IS REQUESTED AT THE TIME OF YOUR VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

We offer the following payment options:

1) Payment by Cash
2) Payment by Check
3) Payment by Credit Card
4) For extensive and lengthy treatment plans
   a) Automatic monthly billing to your Visa. MasterCard, American Express
   b) Monthly financial arrangements (available for some treatment plans)
      (Please request separate form for this option)

Please select your choice, sign below, and return to receptionist before your visit.

Our office is a fully approved and accredited user of the Visa/MasterCard and Amex credit cards to cover payment for dental treatment.

Cancellation of scheduled appointments with less than 24 hours notice or failure to show up for a scheduled appointment will lead to a broken appointment charge. Please schedule appointments that fit into your schedule.

IF YOU HAVE DENTAL INSURANCE A COMPLETED CLAIM FORM MUST BE ON FILE WITH THIS OFFICE. IT IS ALSO YOUR RESPONSIBILITY TO NOTIF US OF ANY CHANGES.WE WILL BE HAPPY TO SUBMIT YOUR INSRANCE FOR YOUR REIMBURSEMENT.

Insurance is a form of reimbursement for fees you have paid to the doctor for services rendered. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages or other limitations based on your contract with them. It is your responsibility to pay the deductible, co-insurance and any other balances not paid for by your insurance. We will assist you in receiving your reimbursement, but you are responsible for your bill.

THANK YOU FOR CHOOSING OUR OFFICE!!

Patient Signature________________________ Date__________

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