

- **Things we need from you**

1. Insurance card
2. Photo ID
3. Visa , Master card , or Debit card

- **RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of any dental and medical information necessary to process claims, and I authorize payment of dental benefits to Afshin Arian, D.M.D. for services rendered. I agree to pay for all services rendered. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge of \$25 will be added. If a collection agency's services are required, I further agree to pay for all legal fees, court costs, reasonable attorney fees, and collection agency fees (50%) in connection with my debt. If debt is not paid within 45 days we will begin to incur interest at the rate of 1.5% monthly or 18% annually until the debt is paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information given to Afshin Arian, D.M.D. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provide a reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule.

Signature of Patient
(If under 18, parent/guardian signature required)

Date

- **APPROVAL FOR THE TREATMENT OF A MINOR**

I authorize treatment of _____ by Dr. Afshin Arian D.M.D.

Parent/Guardian

Date

- **ATTENTION ALL PATIENTS**

We require co-payments for all services before they are performed.

I understand and agree that should my insurance not cover my dental work or a balance is left for more than 45 days on my account my credit card will be charged the amount to bring my balance to 00.00

Payment Preference: Cash/check on day of treatment Debit Card on day of treatment Credit Card

- **BROKEN APPOINTMENTS**

The time that Dr. Arian and our Hygienist have reserved for your appointment is valuable to you and to our office. Broken appointments make it difficult for us to schedule time with other patients. The delay in treatment resulting from a broken appointment can turn a minor problem into a complex one.

If you or your dependent break an appointment with less than a 48 hours notice to our office you will be charged a broken appointment fee. **The fee of \$75.00 dollars will be charged for every ½ hour that was reserved for your care and will apply if sufficient time is not given.**

Responsible party signature

Date