

**IF YOU HAVE DENTAL INSURANCE, PLEASE
CHOOSE ONE OF THE FOLLOWING OPTIONS:**

I hereby authorize Main Line Dental Aesthetics to keep my signature on file and to charge my credit card account for any and all treatment fees remaining after my insurance has processed my claim, or any balance remaining after 60 days. I will be paying my estimated portion at the time of treatment and my credit card number will be securely kept on file.

Cardholder's Printed Name _____

Cardholder's signature _____

Cardholder's billing address _____

Insurance Company _____ Employer _____

Address _____ Group # _____

Home Telephone # _____ Cell _____

Master Card Visa Discover AmEx _____ EXP ____/____

I understand by NOT leaving a credit card pre-authorization on file, I will be required to pay the FULL AMOUNT of my estimated portion at the time of service by one of the following: CASH, CHECK, CREDIT CARD, or 3rd party financing. Main Line Dental Aesthetics will file my insurance claim on my behalf and will request that the benefit be paid directly to Main Line Dental Aesthetics, Inc.

Authorization & Release: I authorize Main Line Dental Aesthetics, Inc to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to Main Line Dental Aesthetics, Inc. all benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services rendered. I understand that regardless of what my dental insurance pays to Main Line Dental Aesthetics, Inc for services I or my family have received, I am responsible for any outstanding account balances or fees associated with non-covered procedures, unless I or my family members are eligible for coverage under a preferred provider agreement. I understand that cash, checks, credit cards or 3rd party financing are acceptable forms of payment.

Print Name _____

Signature _____ Date _____