Agreement to Financial Policy

We have a new financial policy that applies to ALL in-network, out-of-network, and self-paying patients. We now require a credit card on file as a guarantee of payment for any patient-responsible balances.

When in situations where your insurance provider pays its portion and leaves you responsible for the remaining balance, you are accountable to submit this payment within receipt of one **(1)** billing statement. **If no payment is received, your payment will be charged to the credit card information on file with Growing Smiles and will be processed for the balance on your family account.**

Credit Card Information:

Name of Cardholder: _____

Card Type: ____ M/C ____ Visa ____Amex ____Discover

Credit Card Number: _____ **Exp. Date:** _____**CVC:**_____

Card holder Signature: _____ **Date:** _____

Authorized user(s)----------

Name of Patient(s):_____

I hereby authorize Growing Smiles to charge the credit card I have provided, and to keep on file for services rendered, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer.

I have read, understand and agree to this policy.

Print Name: _____ Signature: _____

Date: _____