ARIN LOUSIGNONT DMD
DESERT VIEW DENTAL

1231 E. Basin Road, Suite 10 | 775-727-1366

Pahrump, NV 89060 Fax: 775-727-7116

Person legally responsible for making treatment and financial arrangements:

Name:_____

Phone #:_____

To maintain a high level of professional care, we have established the following payment options. Please check the desired option below:

[ ] OPTION ONE CASH	I will be paying cash for my treatment and no insurance will be used. Treatment will need to be paid in full by cash, check, or credit card.
[ ] OPTION TWO INSURANCE CO-PAY	I will be paying the co-payments or estimated portion at each visit by cash, check, or credit card. Our practice will assist you in filing your insurance claim. The insurance benefits will be assigned to the dental practice directly. INSURANCE IS AN AGREEMENT BETWEEN YOU, YOUR EMLPLOYER AND YOUR INSURANCE CARRIER. ANY REMAINING BALANCE NOT COVERED BY THE INSURANCE, REPONSIBLE WILL BE REPSONSIBLE TO PAY IN FULL.
[ ] OPTION THREE OUTSIDE FINANCING / CARECREDIT	I will be paying using CareCredit or another outside financial company and making monthly payments to them directly. I understand that any financial arrangements made are with the third-party lender and NOT with the dental practice. Account # _____ Allowed Amount $_____

BROKEN AND MISSED APPOINTMENTS:

Appointments reserve a specific time with you and the Dentist or Hygienist to perform and provide the care you need. These scheduled times are planned for your convince and hold great value. Any appointment that is broken or not rescheduled within 24 hours of the appointment, You may be charged a $50.00 fee.

SIGNATURE_____

HIPPA:

Privacy Practice Acknowledgment

I have been given the option to receive a copy of the HIPPA polices and I have had an opportunity to review it.

SIGNATURE_____

BY SIGNING BELOW, I AGREE TO THE FINANCIAL OPTION I HAVE CHOOSENAND FURTHER ACKNOWLEDGE THE FINANCIAL POLICIES SET IN PLACEBY THIS OFFICE.

THE NEED FOR ADDITIONAL DENTAL PROCEDURES AND FEES MY NOT BE COVERED BY INSURANCES, OR ANY THIRD PARTY.

ANY FEES DISCUSSED FOR A TREATMENT PLAN WILL BE VALID FOR SIX MONTHS.

PATIENT SIGNATURE _____

DATE _____