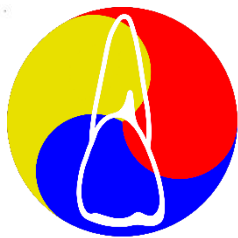


# Dental Tech Team

## Financial Policy

In our continued commitment to provide the highest quality service to all our clients and to have those services comfortably affordable, we are pleased to offer you these options for payment. Please indicate which option will work best for your practice:

❑ I agree to have monthly charges auto billed to credit card VISA. MasterCard, or American Express. All accounts will have 5 days to review statements prior to charge being processed.

❑ Visa ❑ MasterCard ❑ Amex

Number: ______________________________

Exp Date: ______________ CCV Code: ______________

Preferred Payment Date: ______________________

❑ I agree to be billed on 30-day terms. Balances not paid within 30 days of statement are subject to a delinquency charge. Accounts that become 45 days past due will be placed on C.O.D. plus a portion of the remaining balance with each case delivered thereafter until balance paid in full.

Two (2%) per month interest (24% per year) will be charged on accounts not paid within 30 days of statement date. New accounts with a valid credit card on file will be granted a maximum $5,000 monthly credit limit. Should the limit be exceeded, payment will be required to clear the account in order to fabricate additional cases. Larger credit limits can be approved by contacting Diane Bruce at 480.968.6131 in advance.

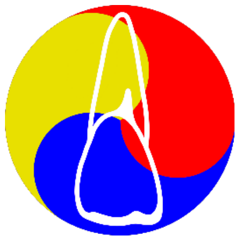
## E-mail Communications:

**I would like the following emailed:** Specific E-mail Address

❑ New Case Confirmation ______________________
❑ Case Shipping Confirmation ______________________
❑ Statements ______________________
❑ Case Hold Confirmation ______________________
❑ CC Change Confirmation ______________________
❑ Invoice ______________________

Doctor's Signature: ______________________________

Dental Tech Team • 2441 E Indian School Rd Suite #102 • Phoenix, AZ 85016
(602) 675-0442 • E-MAIL: info@dentaltechtalk.com



# Dental Tech Team

## New Client Information

To help us better serve you now and in the future, please provide the information below. Please fill out and fax to 480-968-8831 or go to www.golddustdental.com and click on Client Support > New Client Information.

Preferred method of communication: ☐ Office Phone ☐ Text ☐ E-mail ☐ Online ☐ Colleague: ____________________

Practice Name: ____________________

Dr. Name: ____________________ ☐ DDS ☐ DMD

Office Phone: ____________________ Fax: ____________________

Practice E-mail: ____________________

Dr. Cell Phone: ____________________

Doctor's Email: ____________________ ☐ Please do not contact me via cell phone or email. Wait until next business day to contact office, even if case will fail to meet requested deliver date.

Website: ____________________ License #: ____________________

Office/ Shipping Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

Billing Address (If different from above): ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

For Deliveries (Please check days the office is closed): ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

Person Responsible for Payables: ____________________

Email: ____________________ Phone: ____________________

Credit Card Information: ☐ Visa ☐ MasterCard ☐ AMEX

Card Number: ____________________

Expiration Date: ____________________

**All new accounts must guarantee payments by keeping a current credit card on file**

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