HOLISTIC DENTAL AND WELLNESS CENTER

DR. NORMAN BRESSACK | DR. BATOOL F. RIZVI

*Office Address: 1692 Newbridge Road, North Bellmore, N.Y. 11710 | Tel: (516) 221-7447 Email: mercuryfreedoc@holisticdds.com*

**PATIENT FINANCIAL AGREEMENT**

**Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Thank you for the opportunity to help you meet your oral health goals. The estimated cost for your proposed treatment Is $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered as treatment progresses. We will inform you if this occurs and you will be given the option of continuing or changing treatment. (patient initials)\_\_\_\_\_\_\_\_

**PAYMENT OPTIONS:** WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, AMEX AND DISCOVER CARDS. We also offer a No Interest Payment Plan for those patients who prefer to make monthly payments. Ask for an application at the front desk.

**PAYMENT TO BE MADE AS FOLLOWS:**

**⃝ Full payment due on \_\_\_\_\_\_\_\_\_\_\_\_(date) in the amount of $\_\_\_\_\_\_\_\_\_\_\_\_\_**

**⃝ Payment Plan**

**⃝ Partial payment of $\_\_\_\_\_\_\_\_\_\_\_\_\_ due on first appointment and balance of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be paid on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date)**

**CREDIT CARD INFORMATION:**

**Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV: \_\_\_\_\_\_\_\_**

**Name as it appears on Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Billing Address (Street Address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I authorize Holistic Dental and Wellness Center to process the payments using my credit card information mentioned above.**

**Signature of patient or responsible party Date**

**IF YOU HAVE ANY QUESTIONS ON YOUR SUGGESTED TREATMENT PLAN OR THE AVAILABLE PAYMENT OPTIONS, PLEASE DO NOT HESITATE TO ASK. WE ARE HERE TO HELP YOU!**

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**OFFICE COMMENTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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