

# **WOODBURY DENTAL PARTNERS**

## **Financial Statement**

We accept Visa and Mastercard. For those who wish to pay in full when work begins we offer a 10% discount on services \$1000 and over. Patients must pay with cash or check to receive the discount. We understand that some children are not accompanied by the person that is financially responsible; however, payment is due when services are rendered.

I understand that I am responsible for the entire cost of treatment. I further understand that if it ever becomes necessary for the account to be turned over for collection, I am responsible for any collection and / or attorney fees.

## **Insurance Statement**

I authorize the release of any information needed to process my insurance claims. I further understand that I am responsible for the entire cost of treatment regardless of insurance coverage or payments. I authorize payment of insurance benefits directly to the dentist otherwise payable to me.

## **Acknowledgement of Receipt of Privacy Practices Notice**

I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices.

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Signature of Patient or Responsible Party