Continuous Authorization

Grin Central Station Dental LLP
972.608.4746

Grin Pediatric Dentistry is an OUT OF NETWORK provider. This means that Grin Pediatric Dentistry does not have any contract with any insurance company. Because of this, any charges that insurance does not pay will become your obligation to pay. _____ (Initials)

We prefer that arrangements for these balances be made ahead of time with use of a credit card on file.

I, _____, authorize Grin Pediatric Dentistry to retain my credit card on file as part of my dental record, for payment purposes only. After my dental insurance company has paid its portion of the dental services rendered to me at Grin Pediatric Dentistry. I, _____, hereby give my consent to Grin Pediatric Dentistry to charge any outstanding balance to my credit card on file. This balance may include deductibles, denials, and non-covered services.

I have been informed Grin Pediatric Dentistry will keep this signature on file for any estimated patient portion due at the time of service, and any outstanding balance after insurance payment. I understand that the amount I owe provided on my treatment plan is only an estimate and my actual financial obligation may be higher than anticipated depending on my insurance plan.

I understand I have the right to change my credit card information at any time, and I must notify Grin Pediatric Dentistry in a timely manner. I understand this form is valid without expiration until I give a 30-day written notice of cancellation to Grin Pediatric Dentistry.

**Would you like to receive a courtesy call to inform you when we are processing your card?*

_____ Yes _____ No

If yes, we will give you a courtesy call to let you know that there is a balance on your account and that we are processing your card. Please contact the office within 24 hours of this phone call if you would like your card processed on different day. If we do not hear back from you within 24 hours we will process your card.

Account #: _____

Responsible Party Name: _____ Relationship: _____

Credit Card Information:

___Visa ___MasterCard ___Discover ___Amex

Card Holder's Name: _____

Card #: _____ Exp. Date: _____

Address: _____ Zip Code: _____

Cell Phone #: _____ Work Phone#: _____

My signature below indicates I have read the above disclosure, and all information provided is accurate and complete. I agree to the terms of the One Time Authorization as provided above.

Responsible Party Signature: _____

Staff Initials _____ Date: _____ ___Copy to Patient, original filed