STAMFORD DENTAL GROUP, LLC
47 Oak Street
STAMFORD, CT 06905

DEAR VALUED PATIENT:

IN THE INTEREST OF KEEPING OUR PRESENT FEES AS LOW AS POSSIBLE, WE ARE ASKING OUR PATIENTS TO ASSIST US BY PAYING IN FULL AT THE TIME OF SERVICE.

IF YOU HAVE INSURANCE, AS A COURTESY, WE WILL PROCESS YOUR INSURANCE CLAIMS FOR YOU, AS LONG AS YOU PROVIDE US WITH THE PROPER INSURANCE INFORMATION AND CREDIT CARD ON FILE. WE WILL GLADLY ACCEPT INSURANCE REIMBURSEMENT AS PARTIAL PAYMENT. YOU WILL BE RESPONSIBLE FOR ANY REMAINING BALANCE NOT COVERED BY YOUR DENTAL PLAN.

IN ORDER FOR US TO PROVIDE SEAMLESS BILLING, WE ASK THAT YOU PROVIDE US WITH A VALID CREDIT CARD TO KEEP ON FILE. PLEASE UNDERSTAND THAT AS SOON AS YOUR CLAIM HIS BEEN PROCESSED BY THE DENTAL INSURANCE, YOU WILL BE NOTIFIED AND WE WILL CHARGE THE REMAINING BALANCE ON YOUR CARD.

PLEASE ASK US ABOUT OTHER FINANCIAL OPTIONS WHEN TREATMENT EXCEEDS $1,000.00 OR IF YOU HAVE EXTENUATING CIRCUMSTANCES. THANK YOU FOR YOUR KIND COOPERATION,

ACCEPTED CREDIT CARDS; MASTER CARD. VISA AND DISCOVER CARD

_____
PATIENT OR GUARDIAN NAME

_____ V-CODE
CREDIT CARD AND NUMBER

_____
EXPIRATION DATE

PLEASE BE ASSURED THAT THIS INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL AND SECURE