SINH T. TA, D.D.S
CARNEGIE HILL 91ST STREET DENTAL
TRIBECA NORTH DENTISTRY
WEST SOHO DENTISTRY

Credit Card Authorization Form

Our commitment is to provide you with the best possible care. If you have an insurance plan that offers you dental benefits, we always attempt to verify your eligibility and benefit levels. However, all insurance companies state that, *"verbal verification is never a guarantee of benefits or payment."*

We file with your insurance company as a courtesy to you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Our relationship is with you, to provide quality healthcare to you and/or your dependent. Consequently, all charges incurred are your responsibility. The obligation to ensure payment in a timely manner lies with you.

IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE, CO-INSURANCE, AS WELL AS ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY.

Your insurance is a contract between you and the insurance company. We are not a party to that contract. Any amounts not paid by your insurance company ultimately become your responsibility.

PLEASE COMPLETE ONE OF THE TWO BOXES BELOW

I have read and understand the above. I request you submit my treatment to my dental carrier and assign benefits to the provider of service. If I receive a check from my insurance company, I agree to forward this check immediately to the provider of service. If payment is not received within 30 days, or is partially received from my insurance carrier, I understand that I am responsible for any unpaid balance.

I authorize Sinh T. Ta, D.D.S, Carnegie Hill 91st Street Dental and/or Tribeca North Dentistry to charge the credit card listed below or any other card on file for any outstanding balance not paid by either my insurance company or myself. I understand that reasonable efforts will be made to contact me before any charge is made on my account.

Patient Name_____ **Card Holder Name**_____

Acct. Number_____**Acct Type**_____**Exp Date**_____**CVV**_____

Cardholder Signature_____**Date**_____

I do not wish to leave my credit card on file; therefore **I will pay the entire treatment fee up front, and wait for my insurance company to reimburse me.** I request that Sinh T. Ta, D.D.S, Carnegie Hill 91st Street Dental and/or Tribeca North Dentistry submit a claim on my behalf for my insurance reimbursement.

Patient Name_____

Parent/Guardian Signature_____**Date**_____