Payment Information and/or Assignment of Insurance Benefits

Method of Payment

Payment or insurance co-payment is required, in full, at time of service. For your convenience, we offer the following methods of payment. If you have any questions concerning payment or need special arrangements, please ask for assistance.

- Cash or Check
- Credit Card (Visa, Master Card , Discover or American Express)
- Payment Plans (Care Credit, Springstone)

I understand I am financially responsible for all services rendered and agree to be responsible for collection costs, court and attorney fees should collection action become necessary.

X_____ Date:_____
Signature of Patient or Parent (if Minor)

Insurance Information

Patient:_____Patient Date of Birth _____

Primary Insurance Carrier

Policy Holder Employer:_____Insurance Company_____

Name of Policy Holder:_____Date of Birth_____

ID# or SS#_____Group #_____

Secondary Insurance

Policy Holder Employer:_____Insurance Company_____

Name of Policy Holder:_____Date of Birth_____

ID# or SS#_____Group #_____

I hereby authorize Ronald H. Watkins, DDS, MS to furnish my insurance carrier(s) all the necessary information concerning my diagnosis and treatment. I hereby assign to Ronald H. Watkins DDS, MS all insurance payments for services rendered.

I understand I am financially responsible for all services rendered and agree to be responsible for collection costs, court and attorney fees should collection action become necessary.

X_____ Date:_____
Signature of Patient or Parent (if Minor)