Ocala Dental Care
OCALA DENTAL IMPLANT CENTER

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

____ **Payment by cash**

____ **Payment by check**

____ **Payment by credit or debit card**

____ **Payment by Lending Club or Health Credit Services.**

- ✓ **I authorize a pre-approval inquiry and/or application to be entered on my behalf.**

X_____ **(Signature)**

____ **Guarantee any amount not covered by insurance with Visa or MasterCard**

Please make your choice, sign below and return to our office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa and MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

_____

Print your name here and sign below

x _____

Date: _____

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