Canyon Meadows
Dental Care

11646 Elbow Dr. SW
Calgary, Alberta T2W 1S8
(403) 278 3400 Fax: (403) 278 3458

Payment Agreement for Insured Patients

Patient's Name: ____________________

Insurance is an agreement between **yourself** and the **insurance company.** Please remember that we have no control over the benefits and details of your plan. Due to ever changing privacy laws our office will be happy to work with you and your insurance plan, however ultimately **you are responsible for knowing and understanding your insurance plan**.
As the receiver of treatment you are responsible for full payment of your account. If failure to pay in full, you are responsible for any collections or legal fees incurred.
Payment arrangements are required before services are rendered. You may pay your account with Cash, Debit, Visa, or Master Card. Our office does not accept personal cheques. At your request we would be happy to provide you with an estimate prior to any treatment provided. We are here to assist you with the many options we provide.
We do offer direct billing to your insurance company, however the privacy acts have made it difficult for us to retrieve information regarding your insurance and a lot of companies will not pay or communicate with the dental offices. So we ask that a credit card number is left on file with us for security reasons, your card will only be used with your permission and kept confidential. If you are not comfortable with leaving a credit card number on file we ask that you pay us and get reimbursed by your insurance. Please read the following carefully and fill in all the areas below that apply to you.

☐ I will clear my full balance at each of my appointments and collect the payment from my insurance.

OR

☐ I will allow Canyon Meadows Dental Care to collect payment from my insurance and leave a credit card on file. Balance remaining will be assessed to card and receipt mailed to me.

Credit Card Information

Cardholder's Name: ____________________

Credit Card #: ____________________ Exp: __________ Validation Code: __________

Consent

I understand that this form is valid unless I cancel the authorization through written notice.

Signature: ____________________ Date: ____________________

Insurance Information

Please fill in what information you can. Our administration staff can assist you with any questions you may have.

Primary Insurance

Name of policy holder ____________________ Date of Birth (D/M/Y) __________

Name of Insurance (i.e. Sun Life, Alberta Blue Cross…) ____________________

Group or Policy # __________ ID or Subscriber # ____________________

Yearly Maximum __________ How often will your insurance cover a recall exam? __________

Secondary Insurance

Name of policy holder ____________________ Date of Birth (D/M/Y) __________

Name of Insurance (i.e. Sun Life, Alberta Blue Cross…) ____________________

Group or Policy # __________ ID or Subscriber # ____________________

Yearly Maximum __________ How often will your insurance cover a recall exam? __________

Please insure that you notify our office to any changes in your insurance policy