Loreto R. Sicam Jr., D.M.D., Inc.

699 Lewelling Blvd., Suite 300
San Leandro, CA 94579

Phone: (510) 357-8960

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 card

___ Automatic monthly billing to your Visa or MasterCard

___ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to 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 or 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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INSURANCE/ACCOUNT RESPONSIBILITY

PLEASE PRINT INFORMATION

Date:

PATIENT INFORMATION

Patient Name:	Address
	City
	State
Last First MI	Zip

DENTAL INSURANCE

Insured's Name:	Address
	City
	State
Last First MI	Zip
Relation to patient: Self ___ Spouse ___ Parent ___ Other_____	Date of Birth:
SS # or Alternate ID:	Driver's License No.:
Email address:	Male _____ Female_____
Home #: Work #:	Cell #:
Insured's Employer:	
Insurance Name & Phone #:	
Group/Policy #:	
Are you covered under another dental insurance? NO/YES If yes, please complete another form.	

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of my dependents and myself. My signature on this document assigns directly to Loreto Sicam Jr., DMD, Inc. all insurance benefits for dental services rendered. I outhorize the use of my signature on all insurance submissions. This signature binds me as though personally signing any claim. I understand that I am financially responsible far all charges whether or not paid by my insuronce. I authorize Dr. Sicam and staff to perform work on my dependents and myself.

Dr. Sicam's office will verify, explain insurance benefits breakdown and provide an estimate of my financial responsibility before the start of any treatment.

In reading this, I am now advised that Dr. Sicam's office will reach me by phone/email for courtesy appointment reminders and that Dr. Sicam's office reserves the right to charge me $____ far late cancellations, missed or broken appointments without providing a 24-hour advance notice.

_____ _____

Signature of Insured/Patient/Parent/Responsible Party Date

PAYMENT METHODS

Cash	Check	Charge Card	Payment Plan
		No.	
		Exp.	
		CVC	