Jay A. Hollander, D.D.S., P.C.
1255 West 86th Street
Indianapolis, Indiana 46260

INSURANCE INFORMATION

(Please present your insurance card to the receptionist)

DENTAL INSURANCE COMPANY ____

ADDRESS ________________________________ CITY __________ STATE ___ ZIP ______

NAME OF INSURED ________________________________ GROUP/PLAN ID # ______

OTHER INSURANCE ____

IF YOU WISH FOR OUR OFFICE TO PROCESS YOUR INSURANCE CLAIM FOR YOU, PLEASE SIGN THE INSURANCE AUTHORIZATIONS BELOW:

AUTHORIZATION TO RELEASE INFORMATION:

Jay A. Hollander, D.D.S., P.C. is authorized to provide any Insurance company(s) claim administrator(s) and consulting Health care professionals, information concerning health care, advice, treatment or supplies provided.

X ________________________________
SIGNATURE DATE
(PATIENT OR AUTHORIZED PERSON)

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO DENTIST:

I hereby authorize payment directly to Jay A. Hollander, D.D.S., P.C., of the dental benefits otherwise payable to me.

X ________________________________
SIGNATURE DATE
(INSURED PERSON)

FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of treatment rendered to the above named patient(s), to include all members of my immediate family, I accept full financial responsibility. Insurance forms will be completed as a convenience to the patient; however, payment to the doctor is expected at the time services are rendered, unless other arrangements are made in advance. I further agree that if this account is turned over to a collection agency, I will be responsible for all collection agency fees, up to 50% of the principal balance, with interest of 21% A.P.R., court costs and reasonable attorney fees. I also agree and assign any and all insurance benefits to be paid directly to Jay A. Hollander, D.D.S., P.C.

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DATE ____________ SIGNATURE ____

DATE ____________ SIGNATURE ____
RELATION TO PATIENT IF MINOR