PATIENT'S NAME : _____

TODAY'S DATE : _____

Dear Patient,

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

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISITS.

We now offer the following payment options:

_____ Cash
_____ Check
_____ Debit/Credit Card (we accept VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS)
_____ Care Credit

Please make your choice, sign below and return to Office Manager before any treatment.

Our office is 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 your dental expenses.

If none of the above apply, please see the Office Manager, thank you!

Print Name: _____

Signed: _____

Dated: _____

ERICKSEN DENTAL

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