Nil Yücel, DDS
490 Post St. Suite 1038
San Francisco Ca 94102

Consent for Financial Agreement

- ❑ I choose to pay upfront with cash / check / credit card / ATM

C.c. # _____ Exp.Date: _____

3 digit #_____

- ❑ I choose to have my insurance billed and pay the remaining balance on my credit card.

C.c. # _____ Exp.Date: _____

3 digit # _____

For Patients With Insurances:

We will collect your estimated patient portion or co-pay upfront or at the time of services rendered. If the insurance happens to cover more, the overpayment will refund to you. If they cover less than the estimated amount, we will charge your credit card for your remaining balance. We can inform you about the charges;

- ❑ Please charge my credit card without calling for the balance
- ❑ Please inform me prior to the charge
- ❑ Please inform me prior to the charges above_____.

Insurance companies are separate entities that the patients bring along to our office in terms of their financial coverage. As a courtesy to our patients, we will bill your insurance company and follow up. Occasionally, we may need your help to collect payment for the services you had already received. This may actually be more effective since you are the client of the insurance company.
If the insurance company fails to pay the balance after 60 days of the billing, we will ask you to pay the full amount. There will be a late payment charge of 1.5% per month for the outstanding balance.

I understand and agree with the above,

Name_____

Signature_____ Date_____