Joe R. Keneson, D.D.S.
James R. Landis, D.D.S.
1164 Hwy 327 E
Silsbee, TX 77656
409-385-3651

SERVICE PAYMENT AGREEMENT

Patient Name:_____ Date of Birth:_____

- I understand and agree that I am responsible for paying my co-pay and / or deductible at time of service.
- This office is filing my Insurance as a courtesy and will provide me with a treatment plan and estimated payments to be made at time of each appointment. I understand and agree that I will be responsible for all charges not covered by my insurance plan and it is my responsibility to know my Insurance benefits. **Patient /Responsible party is required to be forthcoming with all insurance information, which includes private insurance and Medicaid.**
- Payment in full is expected if you do not have copies of your insurance information or it can not be verified.
- Divorce does not cancel financial responsibility for your minor children *you* bring in for treatment. Remember divorce is a civil action between husband and wife not this office. Your bill is still payable and due. Federal and state laws supersede divorce actions.
- Minor children under age 18 must be accompanied by a parent or guardian to all dental appointments.
- There will be a $25.00 service charge on any returned checks.

We accept cash, check, Master Card, Visa, Discover, and Care Credit.
We can take a payment over the phone by credit or debit card for your convenience.

Please allow the receptionist to copy your Insurance card and driver's license for proper identification. Thank you.

Authorization is hereby given to this office to release any dental or other information necessary to process my dental claims. Authorization is also given for dental benefits to be payable to the provider of dental care services.

_____ _____

Patient or Responsible Party Signature **Date**