George M Kokodynski DDS
6520 N 7th Ave #2
Phoenix, AZ 85013
602-246-9286
staff@dockoko.com

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be:

CASH CHECK VISA MASTERCARD AMX DISCOVER

I wish to discuss the dental office's policy.

_____

Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Kokodynski all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature Date

Late Charges:

If I do not pay the entire new balance within 25 days for the monthly billing date, there could be a charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.