

Financial Policy

Hamid Namazi, DDS
3525 W. Dublin-Granville Rd.
Columbus, OH 43235

I have read and understand the financial policies of Dr. Namazi and Graceful Dentistry. I understand I am responsible for all fees incurred for my dental treatment.

_____ Patient initials

I understand insurance plans are payment assistance programs; they are not designed to cover the entire cost of treatment. I understand my insurance carrier may pay less than the actual bill for services. By signing this form I have authorize assignment of benefits directly to Dr. Namazi and this practice.

_____ Patient initials

I understand I am responsible for any and all charges that might occur if my account is turned over for collections.

_____ Patient initials

Signed _____ Date: ____/____/____
Patient Signature

Parent
Or/ Guardian of: _____
Name of Minor