OASIS
Pediatric Dental Care & Orthodontics

Oasis Pediatric Dental Care
800 West Broad St. Suite 307
Falls Church, VA 22046
(703) 854-1710
(703) 910-5159 Fax

PAYMENT AGREEMENT FOR SERVICES RENDERED
AUTO-BILL TO CREDIT CARD ON FILE

Patient Name:_____________________________________

Responsible Party Name: ________________________

Home Address:

____

____

Home Phone Number: _____- ______ -___________

Credit Card Type: (circle one)

Visa MasterCard Amex Card

Number: _____ - _______ - _______ - _______

Expiration Date: ________/ _________

Please utilize this payment agreement for:

- **Balance remaining**
- **All balances due on visits where I am not present and an alternate responsible party came with my child.**

Charge up to $___unlimited____ of balance/mo./transaction

Any Balance exceeding $___N/A____, Please call responsible party to inform of balance and to authorize transaction.

Please: ___Send or ___ Do Not Send Receipt with each transaction.

I understand that should my insurance company fail to pay my balance in full for whatever reason, I am responsible for the balance on my account which is payable within thirty(30) days. I agree to pay for services provided by Oasis Pediatric Dental Care & Orthodontics. I understand OPDCO will not reprocess claims already denied by my dental insurance. Remaining balances will be automatically charged to the credit card on file.

Signature:____ Date: _________________________