Insurance Co-Payment Agreement

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for services and materials not paid by my dental or health benefit plan. To the extent permitted by law, I consent to your use and disclosure of my personal health information to be used for the sole purpose of collecting any amounts due to the practice.

Agreement Total	$_____
Estimated Insurance Payment	$_____
Remaining Balance (co-payment)	$_____

The remaining balance shown above is to be paid at the initial visit unless other written payment arrangements have been made.

Payment Procedures for 60 days after treatment or receipt of insurance benefit payment (which ever comes first)

I realize that this is only an estimate and my insurance company may pay more or less than the estimated amount. I am paying the estimated co-payment with the understanding that I am still responsible for whatever balance remains after the insurance payment is received. If the actual insurance payment is more than the estimated amount, I will receive a refund of the difference. If the actual insurance payment is less than the estimated amount, I will be notified by mail of the remaining balance due. I agree to pay that remaining balance in full within 30 days. If the remaining balance has not received my payment within 30 days of such notice, I agree to allow the bank account shown on the attached automatic payment authorization to be debited for $_____ per month until the remaining balance is successfully collected.

I also authorize a service fee of $2.50 per payment to be added to each payment if an automatic payment plan is created to collect my remaining balance and that a fee of $10.00 will be collected for each check that is returned as uncollectable.

_____ _____

Patient or Guarantor Signature Date

Instructions to Office-

1. Complete both the Insurance Co-Payment Agreement and the Repetitive ACH Authorization and file BOTH forms. Provide copies of BOTH forms to the patient. DO NOT send either form to DOCPAY until the agreed time has passed.
2. Mail a statement to the patient upon receipt of the insurance EOB or on the 60th day after treatment, whichever comes first. The statement should include a copy of this Insurance Co-Payment Agreement and the Notice of Co-Payment Due.
3. If full payment of any remaining balance has not been received within 30 days of statement mailing, forward a copy of the Repetitive ACH Authorization to DOCPAY. Payments will begin on the first payment date after receipt of the authorization.

NOTICE OF CO-PAYMENT DUE

When your treatment was initiated, an amount was estimated that your insurance company was likely to pay. We have filed your insurance claim but an amount is still due for our services.

Balance before Insurance Payment	$_____
Total Received from Insurance	$_____
Remaining Balance	$_____

Please pay the remaining balance by _____

REMINDER

If the remaining balance is not paid by the above date, per the authorization we have already received from you, a monthly payment of $_____ will be electronically debited from your bank account on the _____ of each month until the entire balance is paid.

(A service fee of $2.50 is added to each payment).

Repetitive ACH Authorization

DOCPAY™

Insurance Co-Payment Plan

* Remaining Balance and Start Date to be determined according to terms of Insurance Co-Payment Agreement

PATIENT/CLIENT NAME	PATIENT/ACCOUNT ID

RESPONSIBLE PARTY (Name on the checking account)

NAME (FIRST-MIDDLE-LAST)	SOCIAL SECURITY NUMBER
	- -
HOME PHONE ( )	WORK PHONE ( )

FINANCING INFORMATION: Monthly payment will be paid directly from your bank account.

REMAINING BALANCE *	MONTHLY PAYMENT + TRANSACTION FEE $2.50 = TOTAL PAYMENT	DEBIT MY ACCOUNT ON THE ☐ 3RD ☐ 10TH ☐ 18TH ☐ 25TH	* Start on receipt of Authorization

"I hereby agree to the 'Terms & Conditions' shown below and authorize the automatic debiting of my bank account according to the above payment schedule until my remaining balance is paid in full. I agree to provide notice of any change to my bank information at least 1 (one) week in advance of the next payment date."

SIGNATURE OF RESPONSIBLE PARTY	DATE

EITHER ATTACH VOIDED CHECK *OR* LIST BANK INFORMATION BELOW.

Bank Name_____ Phone _____

Bank Address_____ _____

City_____ State _____ Zip _____

☐ Checking Account ☐ Savings Account Check # (from sample check)_____

BANK ROUTING NUMBER:	ACCOUNT NUMBER:

TIPS TO IDENTIFY ROUTING AND ACCOUNT NUMBERS:

There are three sets of numbers along the bottom line of your check the Bank Routing Number, the Account Number, and the check number The easiest way to identity each of these is through the process of elimination. First, eliminate the check number. This will leave the Routing number and account number The [: symbols will always be at the beginning and end of the 9 digit Routing Number. The account number is what is left over and will be anywhere from 5 to 16 digits

⑆123456789⑆ 1234 1234567898?

Bank Routing Number Always 9 Digits | Check Number | Account Number 5-14 Digits

FAX COMPLETED FORM TO 800-481-0946

TERMS AND CONDITIONS

DOCPAY is a trade name of Complete Systems, Inc. and has been authorized by the Doctor's Practice to administer this payment plan The transaction fee indicated above is applied each time the Responsible Party's account is debited. Should there be insufficient funds in the account, additional debits may need to be processed. **There is a return charge of $10.00 for all returned items.** Upon default of the above payment schedule due to Insufficient funds withdrawal of the authorization, nonpayment or bankruptcy, the entire unpaid balance may, at the option of the Doctor's Practice, be declared immediately due and owing. In such cases Responsible Party agrees to pay the reasonable cost of collection and/or attorneys fees as permitted by the governing laws of each state. Neither the Practice, Depository nor Complete Systems, Inc. is liable for any incidental or consequential damages stemming from the transfer of funds unless due to fraud or willful misconduct. Responsible Party should receive a monthly statement from the above listed bank showing funds transferred. DOCPAY does not collect insurance payments.

REQUIRED INFORMATION - PAY PLAN CANNOT BE PROCESSED WITHOUT THIS!

PRACTICE NAME **(REQUIRED)**	PRACTICE I.D. CODE	PHONE # **(REQUIRED)**

Your monthly payment will appear on your bank statement showing **DOCPAY ACH** as the payee.

In the event a payment is rejected or returned unpaid, a $10.00 NSF fee will be added to your account.

If you change your bank account, you must notify Practice at least one week prior to your next payment date.

For account changes or any other questions regarding your account please call your practice.

FORM DISTRIBUTION- Make a copy for patient - Keep a copy in patient chart – Fax to DOCPAY DPA Ins Auth- Ver 2.2-09-07