Patient Number ______ A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last ______ First ______ Middle Initial ______ SEX: M F BIRTHDATE ______ AGE ______

Soc. Sec. # ______ If Patient is a Minor, give Parent's or Guardian's Name ______ TODAY'S DATE ______

Who May We Thank for Referring You to our Office? ______ Reason for this Visit ______

RESPONSIBLE PARTY INFORMATION

NAME Last ______ First ______ Middle Initial ______ MARITAL STATUS ______

RESIDENCE Street ______ Apt. # ______ City ______ State ______ Zip ______

MAILING ADDRESS Street ______ Apt. # ______ City ______ State ______ Zip ______

HOW LONG AT THIS ADDRESS ______ HOME PHONE ______ WORK PHONE ______

PREVIOUS ADDRESS (if less than 3 yrs.) Street ______ City ______ State ______ Zip ______ How Long ______

SOCIAL SECURITY # ______ BIRTHDATE ______ DRIVER'S LICENSE # ______ RELATION TO PATIENT ______

EMPLOYER ______ OCCUPATION ______ NO. YEARS EMPLOYED ______

RESPONSIBLE PARTY'S SPOUSE

NAME ______ LAST ______ FIRST ______ MIDDLE

EMPLOYER ______ NO. OF YEARS EMPLOYED ______

OCCUPATION ______ SOC. SEC. # ______

WORK PHONE ______ BIRTHDATE ______

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME ______ RELATIONSHIP ______

ADDRESS ______

CITY, STATE ______ PHONE ______

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______

Insurance Co. ______

Insurance Co. Address ______

Insured's Employer ______

Insured's Soc. Sec. # ______ Group # ______ Local # ______

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name ______

Insurance Co. ______

Insurance Co. Address ______

Insured's Employer ______

Insured's Soc. Sec. # ______ Group # ______ Local # ______

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain	#	LACK of concern	#
COST of treatment	#	MISSING work time	#

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	AIDS/ARC/HIV Pos.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Hepatitis C	Asthma
Rheumatic Fever	Liver Disease	Hay Fever
Congenital Heart Lesions	Blood Transfusion	Sinus Trouble
Mitral Valve Prolapse	Drug Addiction	Allergies or Hives
Artificial Heart Valve	Hemophilia (Bleeding Problems)	Diabetes
Heart Pacemaker	Fever Blisters	Thyroid Disease
Heart Surgery	Epilepsy or Seizures	Radiation Treatment
Artificial Joints (Hip, Knee)	Nervousness	Arthritis
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Glaucoma	Pain in Jaw Joints
Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Alcoholism
Ulcers	Venereal Disease (Syphilis, Gonorrhea, etc.)	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin	Latex (balloons, gloves, etc.)
Nitrous Oxide	Codeine	Penicillin	

Are you aware of being allergic to any other medications or substances? ______

If yes, please list: ______

Is there any other Medical or Dental information that you feel I should know about?

______

FAMILY PHYSICIAN ______ PHONE NO. ______

PATIENT Signature (Parent of Child) ______ Date: ______ DENTIST Signature ______

DIAGNOSIS: MISSING TEETH and EXISTING PROBLEMS

PERIODONTAL EXAMINATION

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

A B C D E — F G H I J

RIGHT — LEFT

T S R Q P — O N M L K

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

TREATMENT PLAN

INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMMATION:	☐ Slight	☐ Moderate	☐ Severe
SOFT PLAQUE BUILDUP:	☐ Slight	☐ Moderate	☐ Heavy
HARD CALCULUS BUILDUP:	☐ Light	☐ Moderate	☐ Heavy
STAINS:	☐ Light	☐ Moderate	☐ Heavy
HOME CARE EFFECTIVENESS:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL CONDITION:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL DIAGNOSIS:	☐ Normal	☐ Gingivitis	
PERIODONTITIS:	☐ Early	☐ Moderate	☐ Advanced

MUCOGINGIVAL DEFECTS #s: ____

CLINICAL DATA:

OCCULUSION: ☐ Class I ☐ Class II ☐ Class III ☐ Crossbite: ____

T.M.J. EXAM: ☐ Normal ☐ Popping ☐ Deviation ☐ Tooth Wear ☐ Pain

INITIAL SOFT TISSUE EXAM:

☐ Lips ☐ Floor of Mouth ☐ Palate ☐ Tongue ☐ Neck & Nodes

INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ☐ FM-PAS ☐ BWX ☐ PANO. ☐ OTHER ____

QUADRANTS

	UR	UL	LR	LL
☐ NO BONE LOSS				
☐ SLIGHT BONE LOSS (04600)				
☐ MODERATE BONE LOSS (04700)				
☐ MAJOR BONE LOSS (04800)				
☐ BEGINNING FURCATION (04700)				
☐ ADVANCED FURCATION (04800)				

☐ OTHER: ____

SHADE

Teeth	Upper	Lower
Cents		
Lats		
Cusp		
Posts		

PERIODONTAL SCREENING & RECORDING

SEXTANT SCORE — MONTH DAY YEAR

EXISTING PROSTHESIS:

NOTES

I acknowledge that I have received the Dental Materials Fact Sheet dated June 2004.

x ____ SIGNATURE ____ DATE

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) ____ Date: ____ DENTIST Signature ____

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that PAYMENT of YOUR bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Our insurance department and patient finance coordinator(s) will work hard to help assure your paperwork if filed accurately and promptly based on the information you have provided our office.

If you prefer to be responsible for your insurance paperwork being filed, then **payment, in full, is due to us prior to any treatment provided.** We are doing your paperwork as a **courtesy**; if your insurance does not pay for all of your charges **it is still** your responsibility to pay the bill in full.

ALL PATIENTS AND/OR GUARDIANS OF MINORS MUST COMPLETE OUR HEALTH HISTORY & REGISTRATION FORMS ALONG WITH ALL FINANCIAL PAPERS (i.e.: Financial Policy, Signature on File, Payment Options) ***prior to seeing the doctors.***

1. TREATMENT FINANCING

PAYMENT IS DUE BEFORE SERVICE IS RENDERED. In order to provide you with the highest quality service while containing billing cost, we must know your method of payment options prior to treatment.

WE ACCEPT VISA, AMERICAN EXPRESS, MASTERCARD, CHECK, DEBIT CARDS AND CASH. WE OFFER PAYMENT PLANS THROUGH CARE CREDIT IN OFFICE FINANCING (based on approval and administration fee.) Our patient finance coordinator will assist you in applying.

2. CANCELING and RESCHEDULING RESERVATIONS IN OUR OFFICE

Other patients also need treatment reservations. When we are notified at the last minute of a cancellation, reschedule, or there is a reservation no show, an opportunity to help a patient is lost. Additionally, many of the Smile Creations staff members are compensated only when they render service to patients. Because of the financial impact that last minute cancellations have on the staff, as well as a matter of courtesy, we have implemented the following cancellation policies:

I. Canceling your RESERVATION and No Shows on the *Doctor's* schedule:

Two business days (48 business hours) **must be given to the office** to reschedule or cancel a reservation for any reason without charge. If the office is given less than the required notice, a **$50.00** per scheduled patient will be charged for cancellations without adequate notice. If a TRUE emergency occurs, please give us a courtesy call.

II. Canceling your RESERVATION and No Shows on the *Hygienist's* schedule:

Two business days (48 business hours) **must be given to the office** to reschedule or cancel a reservation for any reason without charge. If the office is given less than the required notice, the ***Full Fee*** for the services scheduled for each scheduled patient will be ***charged to you.***
At present, the charges for hygienist's services range from $62 to $199.

III. Rescheduling your RESERVATION:

If you have previously rescheduled an appointment twice, a $50.00 cancellation fee will be assessed before a new appointment is scheduled to insure that opportunities to help other patients are not lost, and to defray the costs to staff members caused by the rescheduled appointments.

I read, understand and agree to the above cancellation and rescheduling policies.

Patient/Guardian's Initials: ____________________

3. INSURANCE AND INSURANCE COLLECTIONS

Please understand that insurance reimbursement can be a long and difficult process for any office. In fact insurance companies will routinely stall, deny, and REDUCE reimbursements. Our billing staff is constantly undergoing extensive and rigorous training to maximize your insurance reimbursement while reducing the time in which they pay. Please initial next to your category of insurance listed below, this will help us to speed up payment and eliminate any confusion in the future.

Please check appropriate insurance coverage:	(Please initial)
☐ INDEMNITY (You are not required to select a dentist from a list)	______
☐ PREFERRED PROVIDER PLAN (We are providers for MetLife, Aetna and Delta DPO)	______
☐ SELF-INSURED or UNION PLAN (i.e., Local B 66, CCPOA)	______
☐ GOVERNMENT PROGRAMS (i.e., Healthy Families or DENTI-CAL)	______
☐ DUAL or SECONDARY INSURANCE	______
☐ PIGGYBACK RIDER	______

We bill your insurance as a courtesy to you. If we encounter difficulty in collecting from your insurance company we may at any time ask for the following from you,

-Pre-authorize a letter of insurance stalls.

-Provide us with the name of your human resources director or benefits manager.

-Authorize us to file a complaint letter to the Dept. of Labor and your administrator if necessary.

-Pay your entire bill up front, prior to work being started.

-Pay your unpaid balance in full 45 days from the date of service.

YOU (the Patient) ARE RESPONSIBLE FOR PAYMENT REGARDLESS OF THE INSURANCE COMPANIES ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.

4. DIVORCE DECREES AND COURT ORDERS

This office is ***NOT*** a party to your divorce decree or court orders. Adult patients are responsible for their bill ***AT THE TIME OF SERVICE.*** The adult accompanying the minor is responsible for payment ***AT THE TIME SERVICES ARE RENDERED.***

5. TREATMENT OF MINOR CHILDREN

Adults accompanying a minor to an appointment are responsible for payment at the time of appointment.

6. INTEREST AND REBILLING FEES

We are not a billing service. We reserve the right to charge interest in the amount of 18% per annum provided by state law. At our option we may charge a processing fee or rebilling fee.

Thank you for taking the time to read and understand our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to the Financial Policy.

X________________________________ X______________

Patient/Guardian's Signature — Date

X________________________________ X______________

Patient/Guardian's Signature — Date

INSURED

Authorization for Signature on File
Authorization of Payment

I, ________________________________ hereby authorize the office of Carrington & Henry Dental to affix my name and all claims or documents as related to any and all health benefits due me and my dependents through my employment with ____________________.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Carrington & Henry Dental.

This "Signature On File" will be valid from this date and shall expire in one year.

A photocopy of this document may act as an original.

____________________ Today's Date	____________________ Signature of Insured
____________________ Expiration Date	____________________ Witnessed By

PATIENT

Authorization for Signature on File

Release of Information / Financial Responsibility

I, ________________________________ hereby authorize the office of Carrington & Henry Dental to affix my name to any and all claims or documents as related to any and all health benefits to me.

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

This "Signature On File" will be valid from this date and shall expire in one year.

A photocopy of this document may act as an original.

____________________ Today's Date	____________________ Signature of Patient
____________________ Expiration Date	____________________ Witnessed By

SMILE CREATIONS CALIFORNIA

A beautiful smile for a healthy new you........

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordination, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialist involved in the continuation of your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.

Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and / or leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Office at the practice address listed below:

The *right* to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The *right* to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The *right* to access inspect and copy your protected health information.

The *right* to request an amendment to your protected health information.

The *right* to receive an accounting of disclosures of protected health information outside of treatment, payment and healthcare operations such as appointment reminders, insurance items and any call pertaining to your clinical care, including laboratory results *among others*.

The *right* to obtain a paper copy of this notice from us upon request.

(Be aware health care provider has up to thirty (30) days to fulfill request and may charge patients for the cost)

With your consent, SMILE CREATIONS of CALIFORNIA may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any call pertaining to your clinical care, including laboratory results among others.

With your consent SMILE CREATIONS of CALIFORNIA may mail to your home, or other designated location, any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointments reminder cards and patient statements.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 1, 2003** and we are required to abide by the terms of the "Notice of Privacy Practices" currently in effect. We reserve the right to change the terms of our "Notice of Privacy Practices" and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our "Notice of Privacy Practices" will be posted on the effective date and you may request a written copy of the Revised Notice form this office.

You have the right to file a formal, written complaint with us at the address below, or with the department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

SMILE CREATIONS of CALIFORNIA
Attn: Privacy Officer
120 Ascot Drive, Suite A
Roseville, CA. 95661
(916) 774-1113

For more information about HIPAA or to a file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775 (toll-free)

SIGNATURE:

I, ______________________________, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing the Consent form, I am giving my consent to you to use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ______________________________ Date ______________________

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: ______________________ Signature: ______________________
(Print Name)

Relationship to Patient: ______________________ Date: ______________________

Smile Creations California
Carrington & Henry Dental, P.C.
Sacramento Tel: (916)393-1363 Fax: (916) 393-4853
Roseville Tel: (916)774-1113 Fax: (916) 774-6068

Name:

Address:

Zip code:

Phone number:

Payment Options

To help keep the cost of dentistry down and to continue to provide quality care to our valued patients, we now only accept payment in full, the day of treatment.

Please (√) the option (s) most convenient for you to settle your account in full today.

□ CASH/ check / ATM card (in full the day of treatment.)

□ VISA Account# ______________________________ Exp. Date ___________ CVC# ________

□ MC Account# ______________________________Exp. Date ___________ CVC# ________

□ Am Ex Account# ______________________________Exp. Date ___________ CVC# ________

□ In house credit plan- CARE CREDIT (please see administrative assistant for application form)

I ____hereby authorize Smile Creations California, Carrington & Henry Dental, P.C. to process payment, from time to time as deemed necessary to settle my account if full.

Note: We will run your payment every __________ of the month.

____
Signature of patient/guardian

____
Date

____
Witness (Agent of Smile Creations)

iCare Financial Payment Plan Agreement

975 Cobb Place Blvd. Ste – 317 Kennesaw, GA 30144 - 1-800-862-7908

Merchant Name: Smile Creations California **Merchant Phone:** 916-393-1363

Merchant Email: smilecreationscalifornia@gmail.com

SSN# (Required)

First Name Last MI Male/Female

Present Address City State Zip

Primary Phone Number (Required) Secondary or Work Number (Required) Date of Birth

Personal E-Mail (Required) Emergency Contact Name/Phone/Relationship (Required)

Down Payment and Admin Fee Requirements:

100% of down payment must come from primary debit card attached to your checking account. Administration Fee of 10% is Non-Refundable in the event of a return.

1. Your Payment Plan Begins ____/____/____
2. Amount Payment Plan $ ________
3. Administration Fee 10% $ ________
4. Total Amount of Payment Plan $ ________
5. Less Amount Paid Today $ ________
6. Amount Due $ ________

PAYMENT PLAN SCHEDULE

NUMBER OF PAYMENTS	MONTHLY AMOUNT	MONTHLY PLAN BEGINS

Default and Late Payments: Should you default on any payment obligations as called for in this agreement, *i*Care Financial and/or Merchant will have the right to declare the entire remaining balance due and payable and you agree to pay allowable interest, and all costs of collection, including but not limited to collection agency fees, court costs, and attorney fees. A default occurs when any payment due under this agreement is more than ten (10) days late. Should any monthly payment become more than ten (10) days past due, you will be charged a $20.00 late fee. An additional service fee of $35.00 will be assessed for any check, draft, credit card, or order returned for insufficient funds or any other reason.

X ______________________ **X** ______________________

Merchant Representative **Customer - Responsible Party/Parent or Guardian**

AUTHORIZATION AND AGREEMENT: We/I hereby request the privilege of paying to *i*Care Financial under the *i*Care Payment Plan and hereby request *i*Care Financial or Merchant to draw items, (checks, electronic funds transfer, credit card), for the purpose of paying said payments, including any late fees or service fees. I authorize *i*Care Financial to debit the fees/payments listed above from the primary account listed below. I understand and agree that in the event of insufficient funds in the primary account, *i*Care Financial or Merchant will debit fees from secondary account listed below and or any financial banking account or bank card I should have in the future.

Card Holder Name ______________________ **Bank Name** ______________________

Primary Debit Card Acct# ______________________ **Exp. Date** ____/____

Primary Checking Acct# (Required) ______________________

(DEBIT CARD MUST BE ATTACHED TO A CHECKING ACOUNT - NO PRE-LOADED OR PREPAID CARDS ALLOWED FOR PRIMARY PMT)

Secondary Credit/Debit Acct # ______________________ **Exp. Date** ____/____

(Please Provide 2nd Credit/Debit Card or must indicate "NOT AVAILABLE)

Subject to the following conditions:

1. The items shall be drawn on the date or dates of this Promissory Note. The transactions on your bank statement will constitute receipts for payment.
2. The privilege of making payments under this Plan may be revoked by the Merchant if any item is not paid upon presentation.
3. This Plan, if cancelled, does not release you from your obligation (Promissory Notes/Contract/Consumer Payment Plan Agreement).
4. A service fee will be assessed for any debit card, draft, credit card, or order returned for insufficient funds or any other reason.
5. This Plan shall apply to the following Applicant(s): ______________________
6. I understand and give my consent for Merchant to forward my information to *i*Care Financial.

Print Name ______________________ **Consumer Signature X** ______________________ Date ________

Please attach US Drivers License/ US State ID - Copy of Debit Card and/or a Copy of Credit Card – Copy of Transaction Receipt

Fax all Care Plans to 1-800-317-0675 or Email to admin@icarefinancialcorp.com