GEDALYA RAPOPORT, D.M.D., PLLC
& ASSOCIATES

8 Medical Park Drive
Pomona, NY 10970
(845) 517-2358

Credit Card Information

(**Credit card numbers will be kept confidential**)

Master Card/Visa/Amex Number:

_____

Expiration Date:

_____

Signature Code: _____ ***(3 digits on back of card)***

I, _____***, accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand that it is my responsibility to confirm my insurance eligibility and benefits. I know that any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I give authorization to charge my credit card for any deductibles, co-pays, or claims not paid by my insurance company after 90 days.***