Financial Responsibility Agreement and Consent for Services

Patient name: _____ DOB: _____

Thank you for choosing our practice to serve your dental needs. We appreciate the confidence you have placed in us and will do everything possible to warrant your continued confidence. In order to provide quality service and care to our patients, we ask that you please read and agree to our office policy.

INSURANCE POLICY

Your insurance policy is a contract between you, your employer, and your employer's insurance company. We are not a part of that agreement. We cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.

We will file insurance claims and pre-estimates as a courtesy to our patients. We will do our best to help you maximize your benefits. However, you are responsible for any amount not covered by your insurance.

Please note that insurance pre-estimates are not a guarantee of payment.

We generally accept assignment of benefit from your insurance company but we reserve the right to refuse assignment in certain cases. Full payment will be due at the time of service and your insurance company will reimburse you directly.

When you ask us to submit claims on your behalf, you are agreeing to the following statements:

I authorize and direct payment of the insurance benefit otherwise payable to me, directly to the above named dentist or dental entity.

I understand that it is my responsibility to know what the terms of my insurance are.

I will provide complete and accurate billing information and current dental insurance information.

PAYMENT POLICY

If you have dental insurance, your estimated portion may be due at the time of service, but if you do not have dental insurance, payment for service is due in full at the time of service.

Balances older than 60 days will be subjected to collection fees and finance charges at the rate of 1.25% per month (15% annually).

There will be a $50.00 service charge on all returned checks.

APPOINTMENT POLICY

If it is necessary to modify your scheduled appointment, we request that you give the office 24 hours' notice. Based on the length of your scheduled appointment, a fee of $50.00 per will be billed for missed appointments.

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Patient signature: _____ Date: _____

Responsible party
Signature: _____ Relationship to patient: _____