Financial Policy

*Required Fields

Office Financial Policy

Patient First Name:*

Patient Last Name:*

Patient Birth Date:*

I understand that my dentist and staff will estimate insurance as close as possible. I understand that I am responsible for the payment of the account and providing the correct insurance information.

I understand that if insurance is not applicable when dental services are rendered, my full payment is due at the time of service.

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS:

A. Treatment goes over my maximum benefits.
B. Insurance benefits have been utilized elsewhere.
C. I am not eligible for insurance when services are rendered.
D. I prevent or delay the payment by not complying with requests for insurance forms or signatures.
E. I do not complete my treatment, and it results in non-payment by the insurance company.
F. Lab costs are incurred due to missing appointments.
G. Lab modifications.
H. I received my insurance check and did not send it to your office.

I have read and understand my obligations in acceptance of my dental insurance as payment.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

☐ I have received this policy and agree with its contents.

Signature By Patient

Patient's Signature: *

Sign

By drawing in the box above, I understand and agree that this is a legal representation of my signature

Signature By Guardian

Name: Relationship:

Legal Guardian's Signature:

Sign

By drawing in the box above, I understand and agree that this is a legal representation of my signature

Submit