CONSENT FOR FINANCIAL RESPONSIBILITY

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

*** I understand I am require to give a minimum of 24 hours for cancellations and rescheduling. Otherwise, I am subject to a $50.00 charge.**

AFFORDABLE DENTAL CARE NOTICE TO INSURANCE PATIENTS

I am responsible for my balance if any of the following occurs:

1. Treatment goes over my annual maximum.
2. Insurance benefits have been utilized somewhere else
3. I am not eligible for insurance when services are rendered.
4. I prevent or delay payment by not complying with request for insurance forms or signature.
5. Lab costs incurred during missing appointments
6. Lab modifications
7. I receive my insurance check and do not send it to the office.

I understand that my dentist and staff will estimate insurance benefits as close as possible.

I understand that I am responsible for payment of the account, and providing correct insurance information.

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

Print Patient Name: ____

Relationship to Patient: _________________________________

Signature: ____ Date: ____________________