Patient Responsibility Form

Patient Name: _____ Date: _____

We are pleased to assist you with your dental insurance. If you have dental insurance, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average.

Co-pays:

I understand that I am responsible to pay all co-payment at the time of service, prior to leaving. In the event we are required to take any action to collect any amounts due to us for service rendered you will be responsible for all costs of collection, including reasonable attorney fees, if any.

Deductible:

If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.

I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or with out the use of insurance coverage.

_____

Patient Signature/Guardian Date