ACCOUNT RESPONSIBILITY

METHOD OF PAYMENT:

- ❏ Payment in full at each appointment
- ❏ Payment of portion not covered by insurance at each appointment

Patients on this account:

1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________
5. ___________________________
6. ___________________________

Dental Insurance Statement

Patients who carry dental insurance should understand that fees for health services will be charged to the financially responsible person(s) designated above and not to the insurance company. As a courtesy, this office will file dental claims but we cannot accept the responsibility for insurance collection nor can we negotiate a settlement in a legal case.

Insurance benefits due after 45 days become the immediate responsibility of the person(s) responsible for this account.

Missed or Broken Appointments

A missed or broken appointment without a 48 hour notice is subject to a $50 cancellation fee.
A third missed appointment within a 12 month period is subject to dismissal from the practice.

Signature of Financially Responsible Person:

X ____ Date _________________________

Print Name ________________________________