RESPONSIBLE PARTY INFORMATION

We are committed to providing you with the best possible dental care. If you have dental insurance, we are prepared to help you receive your maximum allowable benefits. In order to do so, we need your complete cooperation. By signing below, you agree it is your responsibility to make sure all filings are made timely and completely and to follow up with your insurance company. You agree that our office is not liable for any decision regarding your insurance coverage or benefits, or for errors or omissions in the filing of claims on your behalf. While our office may assist you in identifying your insurance benefits, the ultimate decision is made by your insurance company on whether services are a covered benefit and how much to pay, if anything. It is your responsibility to verify insurance coverage and benefits prior to the time that services are rendered. Any information we provide concerning benefits is only an estimate and **you are responsible to pay in full for all services, regardless of insurance coverage**.

Our office protocol provides that we allow 30 days for your insurance company to reimburse our office for any fees covered by your policy. As long as we are participating providers, the reimbursement check will come directly to our office. It is important for you to understand that our relationship is with you, the patient, and not with your dental insurance company. By submitting the claim for you, this office has deferred payment by an additional 30 days. This is a courtesy we extend to you and, if necessary, will retract; thereby, making you responsible for all claims submissions. In this case, fees for your services will be due at the time services are rendered.

ALL DEDUCTIBLES AND FEES NOT COVERED BY YOUR INSURANCE WILL BE COLLECTED AT THE TIME OF SERVICE.

If two insurance carriers cover you, we will submit claims to your primary carrier with all fees and deductibles not covered due at the time of service. We will gladly provide all necessary codes for your submission to your secondary carrier.

Returned checks and balances over 30 days past due will be subject to an interest charge of 1.5% per month (18% annually) each month that the payment is outstanding. The returned check fee is $25.00.

In the event that this account is turned over to our attorney for collection, by signing the bottom of this agreement, you agree to pay all collection fees, interest charges, processing fees in addition to attorney's fees (not less than 50% of the outstanding balance) and court costs (a minimum charge of $75.00 will be applied to your account).

We do realize that temporary financial problems may affect the timely payment of your account. We encourage you to communicate with our office in order to arrange financial payments prior to services being rendered. We offer three payment options:

1. Cash 2. Visa/MasterCard 3. Check

In an effort to control the cost of healthcare, we ask that the patients recognize that they are active participants. Appointments are reserved for individual people. We ask that you arrive at least 5 minutes prior to your scheduled time. While circumstances beyond your, or our, control do occur, we ask that you kindly give 24 hours notice for any scheduled changes. Patients that are chronically late or fail to keep their reserved appointments (second occasion) will be charged a fee not less than $25.00 per half hour of reserved appointment time.

This form upon signature applies to all subsequent care provided by our office unless specifically revoked in writing by you. I further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits for services rendered, or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claims.

We thank you in advance for your cooperation in these matters. Please feel free to ask any questions you may have. We are here to help you.

Guarantor (Please print name):_____ Date:_____

Guarantor (Signature):_____