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Patient

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Responsible Party

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Responsible Party SSN

____Yes ____No **I will file all insurance claims and paperwork myself (without any assistance from your office). Total Payment is due when service is rendered.**

____Yes ____No **I would like your office to perform insurance services To the best of their abilities as a <u>courtesy</u> to me. A Portion of my procedure(s) must be prepaid(see below). I understand that ant balance due on the account after 60 days must be paid in full, regardless of Insurance still being processed. Your office is not Responsible for any insurance filing, paperwork, Radiographs, documentation, ect. After 60 days-this Becomes the responsibility of the insured.**

Insurance coverage is estimated. ALL insurance companies state when insurance is verified that the Information provided does NOT guarantee payment for services rendered. Balances are to be <u>paid in full</u> at the time of services. I understand that I will be reimbursed for any and all amounts for services should my insurance carrier pay for these services. I, the patient, am responsible for <u>all</u> amounts not covered by my insurance carrier. If for some reason, the account should become delinquent, (balances greater than 60 days from the date of treatment) I agree to pay for all rebilling charges, interest charges, collection costs, and attorney fees.

Authorized Signature:

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Patient

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Responsible Party

____

Date

A $25 fee will be charged for missed appointment unless rescheduled 24hours prior to appointment date.