CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services.

Eligibility information and benefits provide by insurance are based on the information available at the this time and are subject to all plan provisions. This is not a guarantee of payment. **Final liability , if any cannot be determined until the claim is received and reviewed**. Although insurance does not require it, insurance strongly suggest that a predetermination of benefits be submitted for all charges over $500 or more._____
Patients initials

SCHEDULING APPOINTMENTS/ CANCELLATIONS

We ask all patients to be on time to all your scheduled appointments, if you are 15 minutes late you will be rescheduled. Our office policy requires a 24 hours notice to all appointments that need to be rescheduled. We understand emergencies do happen, but please do give us a courtesy call to make us aware that you will not be able to make it. **There is a $25.00 charge for no shows, broken appointments or failure to contact our office.**_____
Patient's initials

SATURDAY CANCELLATION POLICY

Our office accommodates our patients by opening on Saturdays. Therefore, please be considerate and let us know **24** hours in advance for cancellations in order to reserve the time for other patients. If you fail to cancel within **24** hours or no show on Saturday, we will be forced to charge you **$100.**_____
Patient's initials

PATIENT RESPONSIBILITY

Patient is responsible for notifying the above-named dentist of any charges made at another dental office or dental specialists to avoid going over the maximum benefit allowed by insurance.

If patient does not inform the above-named dentist of charges made by another dentist or specialist, patient will be responsible for payment of treatment not covered by insurance when maximum benefit has been reached.

Insurance does not guarantee payment for services rendered, but patient is responsible for any remaining balances from services rendered to you.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____
Patient Signature (If Minor/Child, Signature of Parent, Guardian or Personal Representative **Date**

_____ _____
Printed Name **Relationship to Patient**