NOTICE TO INSURANCE PATIENTS

(Washington Market Only)

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS:

- The treatment goes over my yearly maximum.
- Any treatment that is denied by my insurance company.
- I am not eligible for insurance.
- I prevent or delay payment by not complying with requests for Insurance forms or signatures.
- I do not complete my treatment and it results in non-payment by the insurance company.
- Lab costs that incurred due to a missed appointment.
- I received my insurance check and do not send it to the office.

I hereby authorize payment directly to the above named dental office. I understand that I am financially responsible for any charges not covered by this authorization. I hereby accept the foregoing treatment plan and authorize release of any information relating to this claim.

I have read and understand my obligation in acceptance of my dental insurance as payment.

NOTICE TO NON-INSURED PATIENTS

I must make financial arrangements for payment of services prior to the commencement of treatment for myself and my dependents.
Any outstanding balance for prior services must be paid before any other dental work is started.

Signed: _____ Date: _____
(Patient or responsible party)

Signed: _____ Date: _____
(Receptionist)