Insurance Disclaimer

(Please Read Carefully)

Please note we do not accept nor participate with DMO/HMO insurance plans, prepay plans, or discount plans.

INSURANCE: Is a contract between you and your insurance company. It is our goal to help you maximize your dental insurance benefits. In most cases, we are not a party to this contract. As a courtesy, we will send the claims for you. Although we may estimate what your carrier may pay, it is the insurance company that makes the final determination of your eligibility and any benefits paid. You agree to pay any portion of the charges not covered by the insurance company.

INDIVIDUAL'S FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for my dental insurance deductible, coinsurance or non-covered services. Co-payments are due at the time of service. In the event that my insurance determines a service to be "not payable", I will be responsible for the complete charge and agree to pay costs of all services provided. It is ultimately the patient's responsibility to know and understand what services are covered under their individual insurance policy, as well as if your insurance plan is in network with our providers. If any changes in your insurance information coverage is not provided or received within the insurance carriers' timely filing period, the patient will become responsible for any balance on the account.

UNINSURED: If I am uninsured, I agree to pay for services rendered to me at the time of service.

MOST IMPORTANTLY: Please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment prior to office visit.

I,_____, have chosen to allow Family Dentistry to file my insurance and I accept full responsibility for this account and for all dental treatment performed upon myself and family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits.

Signature of Patient or Parent/Guardian:_____ **Date:**_____