List of all patients that this financial agreement applies to (please list spouse and kids if you want them included):

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INSURANCE INFORMATION

Primary

Policy Holder's Name ___________________________________ DOB_____________

ID# ______________________ Group # ________________________

Policy Holder's Employer _______________________________

Insurance Company Name ______________________

Insurance Company Address ____

Effective Date of Coverage __________

Secondary

Policy Holder's Name ___________________________________ DOB_____________

ID# ______________________ Group # ________________________

Policy Holder's Employer _______________________________

Insurance Company Name ______________________

Insurance Company Address ____

Effective Date of Coverage __________

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services or any dental services performed without insurance coverage must be paid in full at the time services are rendered.

Your agreement with the insurance company is between you and your insurance company. Any assistance by the doctor and/or staff in filing of insurance papers or confirmation of insurance payments is strictly given as a courtesy and implies no responsibility on their part for follow up confirmation. If the insurance company does not remit payment within 60 days after the date of service, we will bill you with the remaining balance due and payable upon receipt from you. A 1.5% charge per month will be added to the unpaid balance unless an arrangement has been made in advance with our billing specialist. We are happy to file necessary forms to ensure that you receive full benefits of your policy, but make no guarantee of payments or any estimated coverage.

This signature on file is my authorization to release any information to the insurance company to process my claim. I hereby authorize payment of my group insurance benefits to the dentist if any claims were filed by the dentist. I hereby certify that I fully read the above and agree with all terms and conditions.

_____________________________________ printed name _____________________________________ date

Printed Name of Patient/Parent/Guardian Date

_____________________________________signature _____________________________________ email

Signature of Patient/Parent/Guardian email address