Insurance Authorization

I, _____, authorize and request that my insurance company pay directly to the dentist or the dental group insurance benefits that are otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services or may even deny certain services as they pertain to my contract with the insurance carrier.

I understand that my insurance is being filed as a courtesy. It is my responsibility to find out if I have coverage under my current plan and if the doctor is a provider. I understand that I should have all insurance information with me and it is my responsibility to know all the correct information pertaining to it. Should my plan change I will notify you either at my next appointment or I will send you a copy.

Signature: _____ Date: _____

Payments

I, _____, understand that unless previously arranged that payment for rendered services is due at the time of service. Any arrangements made should be done at the front desk and are made as needed for treatment plans. **If monthly payments are arranged then it is understood that if a payment is not received after 30 or more days from the statement date then a late payment charge of $5 will accrue every month that the account is not being paid on.**

I agree that I am responsible for any amount that is not paid by the insurance on services rendered for me and any dependents. **I understand that I need to cancel an appointment at least 24 hours before it is scheduled. If I no show or cancel day/time of appointment there will be a $25 fee per hour of the appointment.**

Any estimates done for a treatment plan is just that; an estimate. I know that I may owe more or less depending on what insurance pays for the rendered services.

Signature: _____Date: _____