

## Self-Pay Patients

Payment for services rendered is expected in full at the time of service. If that is not possible and special arrangements are necessary, you should inform us prior to the date of your appointment so that we will have time to discuss those arrangements.

## Insured Patients

It is the patient's responsibility to be fully aware of all provisions of his/her insurance policy. If your insurance company does not pay your claim within sixty (60) days, the balance remaining on your account becomes your responsibility.

We participate with several insurance companies and, as a courtesy to our patients, we welcome the opportunity to process your claim for reimbursement, regardless of whether we participate with your carrier or not. We request your insurance information prior to your appointment so that we can obtain a breakdown of benefits from your carrier(s). Any information given by your insurance carrier is strictly an estimate of benefits. The co-payment and/or deductible requested at the time of service is derived from information given from your carrier. Your insurance company will not guarantee any payment amount until a claim has been filed. We cannot be held responsible for incorrect information given by your insurance carrier.

If we file your insurance claim, payment of any co-insurance and/or deductibles is required at the time of service. You will need your insurance card for us to file your services to your carrier. If you do not provide us with your insurance information at the time of service, you will be considered under the self-pay payment plan and fees will need to be paid in full at the time of service.

## Estimates

Our office provides an *estimate* of the fee of any procedure prior to treatment. This fee may be altered based on degree of difficulty involved in the procedure or in the actual services rendered.

I agree to be responsible for all reasonable attorney fees and collection costs in the event that my charges default to me, as outlined in the office financial policies guidelines.

By signing this, I acknowledge that I have read and understood this financial policy.

Name: *(print)* \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Guarantor Information

Person responsible for this account: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

***\*Special note: The practice cannot bill anyone other than the individual who has signed for financial responsibility.  
\*You will be asked to sign this document upon arrival for your appointment.***

**Submit Form**