STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree to the following general responsibilities:

- Financial options extended to me are based on the personal identification
- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, as well as any additional expenses incurred in connection to my healthcare, such as: postage and delivery, shipping and handling, and phone calls to the provider or clinic wherein medical advice is provided.
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize DENTAL CLINIC to release information necessary to secure payment.
- I understand that there will be a minimum $50 fee for any appointment not cancelled within 24 hours of the scheduled appointment.

I understand and agree to the following with regards to current and/or future insurance billing:

- The verification of my health insurance is used to determine if there are coverage services through my insurance carrier and is not a guarantee of payment by my insurance; I am fully responsible for being aware of any coverage exclusion.
- I am responsible of providing in a timely manner all accurate, current information and documentation required to verify my insurance coverage and/or bill my insurance, including all relevant coordination of benefits information such as primary and secondary insurance, Medicare, Medicaid, etc.
- I am responsible for full and timely payment of all insurance co-pays, deductibles and coinsurance balances due, including any and all services not covered or paid by my insurance
- I am responsible for full payment of all services if any of the information I have provided is incorrect, falsified and has results in DENTAL CLINIC inability to directly bill for services reimbursement from my insurance.
- I may forfeit the privilege of billing my insurance if I don't comply with any of my financial reasonability or documentation requirement.
- I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to DENTAL CLINIC. This release applies to support of the insurance billing process only. Separate authorization may be required for other entity requests. I have fully read and understand the above agreements and authorization.

I have fully read and understand the above agreements and authorization

Patient (18 years or older) _____ Date_____ Signature_____

Parent, Guardian, Responsible Party _____ Date_____ Signature_____