WEATHERHILL DENTAL

DENTAL INFORMATION AND PAYMENT RELEASE/FINANCIAL RESPONSIBILITY

I authorize the release of dental information to insurance carrier and/or their agents. I also authorize payment of the dental benefits to be made directly to Weatherhill Dental. I understand that payment is due at the time service is rendered to me, unless my insurance company is being billed for the service provided. I understand that I am responsible for payment at the time of the visit if my insurance company pays me directly or procedures performed are not a covered expense under my plan. I understand that all co-payment amounts are due at the time service is rendered. Furthermore, if through the normal course of insurance submission, the insurance company does not pay, I understand I am responsible for payment.

SIGNATURE_____**DATE**_____
RESPONSIBLE PARTY, PARENT/GUARDIAN IF UNDER 18 YEARS OF AGE

OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts.
3. New patient emergency visits and non-covered procedures must be paid for at time of visit.
4. Benefits are calculated according to your insurance and co-payment amounts are due at the time of visit.
5. Any unresolved insurance claims over sixty (60) days become the responsibility of the patient, and need to be paid in full to our office.
6. As the responsible party you understand that this account is subject to additional collection/court/administrative fees if this account becomes delinquent.

SIGNATURE_____**DATE**_____
RESPONSIBLE PARTY, PATENT/GUARDIAN IF UNDER 18 YEARS OF AGE