Insurance Disclaimer

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under you policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment for services from their insurance carrier. We do expect the patients to be interactive and responsible for communicating with you insurance carrier on any open claims. Keep in mind that the information we receive from your insurance company is third party information. We are not responsible for any changes made with your insurance policy.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. **Even a preauthorization of services does not guarantee payment from your insurance carrier.** We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reduction such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contract with you carrier we will not negotiate reduced fees with your carrier

_____(initial)

Cell Phone

☐ I, consent to the dental practice using my cell phone number to: (choose one or both)
☐ **call** or ☐ **text** regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cell phone # is
(include area code) _____

_____(initial)

Cancelling Appointments

As a courtesy, we routinely call our patients to remind them of appointment dates and times at least one day in advance. In order for us to maximize services to all patients, we request that you notify us if you need to cancel your appointment **48 hours in advance** of your scheduled appointment time . Otherwise, a missed appointment fee of **$50.00 per** hour will be charged to your account. After 3 missed appointments, we reserve the right to dismiss you as a patient.

_____(initial)

Patient Signature:_____ Date:_____