Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality compassionate care and service to all of our patients. The following is a statement of our financial policy. We ask that you read below and agree to prior to any rendered treatment.

- Please understand that payment of your bill is considered part of your treatment. Patients with dental insurance are responsible for paying any co-payment, deductible, **or** fees for *non-covered* services at the time services are rendered. We will be happy to give you an estimated treatment plan, however this *is only an estimate* and the patient is ultimately responsible for any payment not covered by insurance. We accept cash, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you fill be financially responsible.
- As a courtesy, we will bill to your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by your insurance company.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your insurance card and ID for our records. Providing a copy of your insurance card does not confirm that your services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
- We kindly ask that you provide us with at least a 24-HOUR notice of cancellation. Any appointments not canceled and/or rescheduled within a timely manner will be charged a $50 missed appointment fee per hour.

I authorize D.A. Dental to release all information necessary to secure the payment benefits to third party payors and request insurance company to pay directly to D.A. Dental insurance benefits otherwise payable to me. I understand that if my insurance company denies coverage and/or payment for services provided to me (or my dependent), I assume financial responsibly and will pay all such charges in full.

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Signature of Patient/Responsible Party | Date

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Name (print) of Patient/Responsible Party | Relationship to Patient