FINANCIAL AGREEMENT

I understand that as a courtesy to me, the dentist's billing staff will file all claims for services rendered to my insurance carrier.

I, however, acknowledge that I am responsible for any balances that may be due to the dentist because of:

- Co-insurance or co-pay amounts
- Yearly deductible
- Non covered services
- Out of network charges
- Terminated coverage
- Exhausted auto benefits
- Denied workers compensation claim
- No insurance coverage
- Failure to respond to insurance carrier correspondence
- Failure to respond to coordination of benefits inquiry

I ______________________________ agree to pay any charges not covered by my insurance. This amount may be more than the 30% that I have already paid.

I further understand that I may need to make monthly installment payments on this balance and the front desk will work with me to have this balance paid in full in a reasonable length of time.

We as your dental provider will be happy to file your insurance claim, but it is ultimately your responsibility to work with your insurance company to get claims paid if problems arise.

Name____________________

Date____________________