Notice to Insurance Patients

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS:

A. The treatment goes over my yearly maximum.
B. I have not paid my co-payment or reached my deductible
C. My insurance company denies any treatment
D. My insurance company pays less than estimated / 100%
E. I am not eligible for insurance
F. I prevent or delay payment by not complying with requests for insurance forms or signatures
G. I do not complete my treatment and it results in non-payment by the insurance company
H. Lab costs are incurred due to missed appointments
I. I received my insurance check and did not send it to your office

I hereby authorize payment directly to Robert C. Apuy, DDS, Inc. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

It is my responsibility:

A. To know the coverage and maximum for my insurance.
B. If I need prior authorization to know what my insurance will/will not cover, I can request it for any treatment.
C. To request for my insurance maximum to be checked by your office if I am not sure of the remaining benefits coverage. The office checks patient insurance coverage and bills for procedures as a courtesy to the patient.

I have read and understand my obligations when using my dental insurance as payment or partial payment for my treatment.

Signed: _____ Date: _____
(Patient or responsible party)

Signed: _____ Date: _____
(Receptionist)