

**Patient Responsibility And Consent Agreement**

I hereby authorize and request the performance of necessary dental services for myself, \_\_\_\_\_, and/or for the dependents listed:

name(s): \_\_\_\_\_

I understand and acknowledge that I am financially responsible for the services provided for myself and/or the above named, regardless of insurance coverage.

If unable to keep your appointment, please call the office within 24 hours of your appointment time. If you miss your appointment or cancel without 24 hours notice, you will be charged a \$25 fee. It is very important to arrive on time. Please call us if you know that you will be running late. If you are more than 10 minutes late, we may need to reschedule your appointment.

Children 17 years of age and under require the presence of a parent or legal guardian before any treatment is performed.

I have read, understand, and agree to the provisions of the Patient Responsibility And Consent Agreement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Important Information Regarding Insurance**

We will file insurance claims and pre-estimates as a courtesy for our patients. However, please be aware that your insurance is a contract between you, your employer, and the insurance carrier. We are not a party to that contract.

\_\_\_\_\_ (Initials)

Not all services are a covered benefit in all contracts. Some insurance companies/employers arbitrarily select certain services they will not cover. Our office is not responsible for monitoring each contract limitation.

\_\_\_\_\_ (Initials)

Any information our office gives you regarding your insurance coverage is an estimate. We make these estimates based on the information made available to us by the insurance company. We are not responsible for any decisions regarding payments that the insurance carrier makes. We will do our best to accurately maximize your benefits, however you are responsible for any amount not covered by your insurance plan. Your estimated co-payment and/or deductible will be due at the time of service.

\_\_\_\_\_ (Initials)

**Insurance Assignment And Release**

I, the undersigned certify that I (or my dependent) have insurance coverage through \_\_\_\_\_ and assign directly to Rose City Dental Care all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature \_\_\_\_\_ Date \_\_\_\_\_