AHAVA DENTAL

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I, _____, understand and agree that it is **my responsibility** to know my insurance coverage, including **benefits, deductibles, and co-payments**, and how it applies to dental treatment in this office. Presenting my insurance card does not guarantee payment by my insurance company. **Regardless of my insurance status**, I am ultimately responsible for the balance of my account for any professional services rendered. This includes any **deductibles** I have not met and any **co-payments** for which I am responsible.

I have read all the information on the patient's information and medical history form and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in my insurance status or any changes to my patient information record immediately.

In addition, **missed or broken appointments** greatly affect our practice and any delay in treatment can significantly affect your dental condition. Therefore, any appointments missed without at least 24-hour notification may result in a charge to your account.

Do not sign this form unless you completely understand all the consequences of your visit and the charges you are responsible for.

I **understand all** the information on this form and wish to receive professional dental services from this office.

_____ _____

Patient (Responsible Party) Signature Date