Out-of-Network Insurance & Financial Responsibility Acknowledgment

Our office will contact your insurance to obtain any precertification if required. Any outstanding deductible, coinsurance, or copayments are collected at the time of booking. We accept cash and debit/credit cards/Care Credit/ Cherry for payment.

Patient Initials: _____

Please keep in mind we provide ESTIMATES ONLY, based on information given to us by YOUR insurance company. We cannot be held responsible for any misinformation provided by them. We strongly encourage you to contact YOUR insurance company to verify benefits. Your estimated amount due is not the final determination of your claim or the final amount you may owe. **Your insurance company makes the final determination on the dollar amount they'll cover after services are rendered and the claim is processed.** We provide the closest estimate possible based on our experience and industry standards.

Patient Initials: _____

We strive to provide our patients with optimum dental treatment in the most comfortable and caring environment, and we make every effort to help our patients receive the maximum benefits from their insurance company. To assist us, please provide complete and accurate insurance information so claims can be filed promptly.

Patient Initials: _____

IMPORTANT: Our office is OUT OF NETWORK with all dental insurance networks. We have intentionally chosen not to participate in discounted networks because they often compromise quality of care in favor of reducing reimbursement. Our commitment is to provide the highest standard of dentistry without insurance companies dictating the quality of your treatment. As a courtesy, we will gladly file your claims based on the information provided by your insurance company and estimate your portion. Your estimated portion is due at the time services are provided.

Patient Initials: _____

We have found that insurance companies are more likely to process claims promptly when patients are actively involved in communicating with their insurer. The relationship is ultimately between you and your insurance company. Insurance carriers are generally expected to process claims within 60 days. If payment is delayed or denied, you are responsible for any remaining balance.

Patient Initials: _____

Patient Acknowledgement
I acknowledge that I have completely read and understand the statements above. I understand and acknowledge that this dental office is **OUT OF NETWORK** with my insurance plan. I understand that any estimates provided are not guarantees of payment and that I am ultimately responsible for any balance not paid by my insurance company.

Patient Name	_____
Patient Signature	_____
Date	_____
Witness	_____