PUGH FAMILY DENTAL

Financial Responsibility Form

Date:_____

Patient Name:_____

If verification of my dental coverage cannot be made at this time, I agree to pay for any and all dental services I receive from the doctors and ancillary providers (laboratory fees, etc.) of this practice should my insurance company refuse to pay for my care.

I understand that dental insurance coverage is only an *estimate* and may change due to benefit coverage or services rendered.

Should my dental insurance carrier refuse payment (e.g., non-covered services, no benefits for certain procedures, reached maximum benefit for the year, etc.), I will pay for all services rendered upon receiving a written and/or verbal notice of the denial of my claim. Failure to pay within 60 days of filing is, for the purpose of this agreement, a refusal to pay. In the event I do not pay for these or any other services provided to me when due, I agree to pay all costs associated with the collection agency.

I further agree and understand that this office can only code and file a claim for my visit(s) with the diagnosis that was encountered and documented in my dental record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

Last Minute Cancellation Policy

Our office understands there may be times when appointments need to be rescheduled short notice due to unforeseen circumstances. In this case our office will make every effort to work with patients in this event.

If for any reason something comes up and you are not able to make your scheduled appointment, please let us know at least 24 hours in advance. Otherwise this will result in a prepayment charge to reschedule your appointment. This policy helps us keep our operating costs as low as possible for all our patients.

By my signature, I certify to having read the above statement and fully understand my financial responsibility for all care rendered to me so long as I am a patient of this practice regardless of any changes in my dental insurance coverage.

Thank you for your cooperation.

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Patient signature (or responsible party if a minor)