BURCHWOOD
DENTAL

Insurance/Financial Understanding

I, _____, understand that any treatment plans and prices discussed with the office of BurchWood Dental are estimated charges and once my insurance company processes my claim there is the possibility I will still have a balance due. I also understand if my insurance does not cover its portion, I am then responsible for the entire balance.

I agree that all charges remaining on my account that have not already been paid and were not covered by my insurance, I will pay to BurchWood Dental upon receipt of an invoice.

If any payment is not made by its due date, I understand that I may be charged additional fees and if my account is not paid in full after 90 days, I understand that my account will be sent to a collection agency.

If I am unable to pay the outstanding balance on my account, I understand that I need to contact the office of Dr. Stacie Burch to discuss payment options.

Patient Name (Print): _____ Date: _____

Patient or guardian Signature: _____

Names of family member, friends and relatives we may disclose patient info to:

1. _____
2. _____
3. _____