

Healthy Smile Dental

Dear Patient:

Our office is most happy to complete and submit most insurance claim forms. We accept most dental insurance plans including indemnity insurance and Preferred Provider Organization (PPO) plans. Please keep in mind that most insurance companies **do not cover all** dental expenses. We encourage you to discuss any questions you may have regarding your specific plan with our office management and insurance department staff. Questions regarding your dental care should be discussed with your doctor. Thank you for the opportunity to serve you.

Please read and sign below showing you have understood the following:

- ❖ I understand that my insurance policy may/may not cover all dental services and that it is my responsibility to call my insurance company to verify my/my family's coverage on dental procedures to be performed on me/my family.
- ❖ My insurance plan may have a deductible and/or copayment amount which is due at the time of service. I understand that I will be responsible for any other balance **not** paid by my insurance company.
- ❖ Any Flex Plan reimbursement will be paid directly to me upon submission of my **paid** receipts to my company.
- ❖ I accept full responsibility for all fees required for my child's/children's dentistry, regardless of my marital status.
- ❖ I understand there is a charge for failing an appointment or canceling without 24 hours notice.
- ❖ In the event that I/my family want to transfer to another office, I understand that my/my family's balance must be paid in full to receive copies of dental records. There is a charge for duplication of x-rays at the request of me or my insurance company.
- ❖ I understand that if my check payment is returned NSF from the bank, there is a \$35 NSF charge which will be added to my account, and I may be asked to make payment by credit card, money order, or cash only.
- ❖ I understand that I am responsible for any reasonable fees, expenses, or costs related to the collection of any unpaid balance, including but not limited to late charges, referral costs, and commissions paid to attorneys or collection agencies.

Patient/Guardian Signature

Date