



Financial Policy/ Insurance Disclaimer

1. I understand that all co-payments are due at the time services are rendered with the payment options being:
 - Cash
 - Check
 - Master Card
 - Visa
 - Discover
 - Care Credit
2. I understand and agree that this dental office does NOT represent my dental insurance company and this office CANNOT make any representation or warranty that my dental insurance company will cover all or any portion of the dental services provided by this office.
3. I realize that such payments will include amounts incurred from deductibles, co-payments and amounts not paid by my dental insurer due to exhaustion of my benefits.
4. I acknowledge that it is my ultimate and sole responsibility to determine whether a dental service, procedure or treatment program is covered by my dental insurer and if covered, the amount of coverage that will be provided and whether my benefits are exhausted or will be exhausted during the service, procedure or program.
5. I also acknowledge and understand that this office will not, as a matter of policy, agree to halt any service, procedure or treatment program solely because my dental insurance benefits have become exhausted and I certainly understand that this office can not know at what point in my procedure or treatment my insurance benefits will exhaust.
6. I confirm that no representation had been made to me by any one in this office that is contrary in any way to the above notice and disclaimer.
7. I further confirm that any statement made by any one in this office concerning my dental insurance coverage cannot be relied upon as a guarantee of coverage.

Patient/Guardian

Date