ATTENTION

Our dental practice will file your insurance benefits as a courtesy to you. If your insurance company is out of network, you will receive a bill for the remaining balance after we receive the insurance payment. It is your responsibility to contact your insurance and verify your benefits and to find out if this is a participating practice with your plan. By signing this form, you acknowledge that you may owe a balance and are responsible for payment if your insurance is not contracted with out office or if there is a balance after insurance pays out its portion.

_____

Print Parent/Guardian Name Date

_____

Parent/Guardian Signature Date

_____

Patient's Name