Dentalworks Family

Statement of Patient Financial Responsibility

Patient/s Name: ______________________________ DOB: __________________

Dentalworks Family appreciates the confidence you have shown in choosing us to provide for your child's dental care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for your payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your child's dentist elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to the Dentalworks Family for providing restorative services to the above named patient. I certify that the information is to the best of my knowledge, true and accurate. I authorized my insurer to pay any benefits directly to the Dentalworks Family, the full and entire amount of bill incurred by the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient signature_______________________________________ Date________________________

Guarantor signature______________________________________ Date________________________
(If guarantor is not the patient)

Co-pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor signature_________________________________Date______________________

Consent for treatment & authorization to release information

I hereby authorize the Dentalworks Family, through its appropriate personnel, to perform or have performed the above named patient, appropriate assessment and treatment procedures.
I further authorize the Dentalworks Family, to release to appropriate agencies, any informationacquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor signature___________________________________Date______________________