Notice to Insurance Patients

I understand that I am responsible for my balance with Seto Family Dentistry, including the following circumstances:

A. The treatment goes over my Insurance company's yearly maximum benefit
B. My Insurance company denies treatment
C. I am not eligible for Insurance
D. The insurance benefits are less than what was indicated on Osinde Family Dentistry Estimator
E. I prevent or delay payment by not complying with requests for insurance forms and signatures
F. I do not complete my treatment and it results in non-payment by any insurance company
G. Lab costs are incurred due to my failure to appear at my appointments
H. I RECEIVE MY INSURANCE CHECK AND DO NOT SEND IT TO OSINDE FAMILY DENTISTRY

I HAVE READ AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE. IF THERE IS A DIFFERENCE BETWEEN YOUR PORTION AND THE INSURANCE COMPANY'S PAYMENT, WE WILL SEND YOU A STATEMENT FOR THE BALANCE.

Please note that we are an out of network provider: However, we file claim forms electronically, provide postage for special claims and track claims as a courtesy to our patients. We make every effort to accurately estimate your benefits prior to your appointment, however, most insurance companies do not give accurate estimate until the actual claims are received and processed. The benefits we are given by the insurance company are an ESTIMATE only and not a guarantee of payment.

On the day of your appointment you will be asked to pay the portion that we estimate the Insurance Company will not pay based on your coverage. We then file and the Insurance portion will be paid directly to our office. If the insurance check is sent directly to you, then you will be asked to pay the entire portion at the time of treatment.

SIGNED: _____ DATE: _____
(Patient or Responsible Party)

_____
(Print Patient or Responsible Party's Name)