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Financial Responsibility Agreement

* **It is important for you to provide the office with complete insurance information** for all carriers with whom you are insured at the time of service.  At each office visit we need you to show us your insurance card to insure that your current insurance information is on file.
* As a service to our patients, we will submit your insurance claim to your primary insurance company.  Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company.  However, **it is the patient’s parent or guardian responsibility to know the insurance coverage and benefits limit of their particular policy.**
* If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance.  **If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly**.  You may contact your insurance company for reimbursement.
* Insurance is a patient’s benefit designed to assist the patient in their financial obligation to Dinosaur Dental.  The patient is the one receiving the dental service and therefore their parent or guardian is ultimately responsible for all charges on the account regardless of any insurance coverage.  This applies to everyone in the family who is treated at Dinosaur Dental.
* **The office will collect the patient’s deductible and the estimated balance after the primary insurance payment at the time of service**.  After the primary insurance payment is received, the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment.  If the insurance payment is greater than the estimation, we will either refund the amount to the patient or leave the credit balance on the patient’s account to be applied toward future treatment.
* In the event that the patient does not have insurance coverage, charges for services are due and payable at the time services are rendered, unless a signed financial agreement has been approved.
* You are responsible for any balance that is not paid by insurance within the 90 day period. Again, it is your responsibility to provide our office with updated insurance information on or before the date of service.

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_