DIBBLE FAMILY DENTAL

RESPONSIBILITIES & RELEASE

I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize my doctor to release all information necessary to secure payment of benefits. I authorize and request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me. I authorize the use of my signature below on all insurance submissions. I understand that my dental insurance may pay less than the actual bill of services.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT _____

OFFICE GUIDELINES

- As a courtesy to you we will bill your insurance; however this is NOT a guarantee of insurance payment. Payment of dental services not covered or paid by your insurance is required at the time services are provided.
- For your convenience financing may be obtained for full and/or partial treatment through CareCredit, a third party financing company. We can help you with the application process.
- **YOUR APPOINTMENT IS SPECIFICALLY RESERVED FOR YOU.** A fee of $75.00 PER APPOINTMENT MAY be charged to and paid by the patient for any appointment that is canceled without at least a 48 hour notice.
- A 1.5% per month (18% annually) finance charge may be added to any account with a past due balance of 90 days starting from the date services are rendered.
- We do not accept DSHS, Medicare, or Medicaid.
- Nitrous oxide is available at $90.00. Payment is due at the time of service. This is not covered benefit on any insurance plan.
- All deductibles and co-payments are expected at the time of service.

I have read and understand the above stated guidelines and services.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT _____