IntegrityDental

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Integrity Dental as your dental care provider. We are committed to providing you with the highest quality dental care. We ask that you read and sign this form to acknowledge your understanding of your patient financial responsibilities.

Patient Financial Responsibilities

- The Financially Responsible Party as identified on the Patient Information form and who signs on this form is ultimately responsible for the payment of treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Co-pays are due at the time of service.
- Co-insurance, deductibles, and non-covered items are due within 30 days from receipt of billing.
- In the event that a dental insurance plan determines a service to be “not payable”, the Financially Responsible Party will be responsible for the complete charges and agrees to pay the costs of all services provided.
- Patients may incur, and are responsible for payment of additional charges, if applicable, such as:
    - Charges for returned or cancelled checks or other bank fees associated with a payment.
    - Charges for missed appointments without 24 hours’ notice.

By signing below I acknowledge I have read, understand, and agree to my financial responsibility as discussed on this form. I hereby authorize assignment of financial benefits directly to Integrity Dental and any associated dental care entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

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Printed Name of Financially Responsible Party

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Signature of Financially Responsible Party Date