Insurance Guarantee of Payment and financial form

Please fill out this form. We need this information to submit to your insurance company. **WITHOUT THIS INFORAMATION YOU CAN NOT BE SEEN.**

Subscriber Name: _____ Birthday: ____/____/____

Insurance Company Name: _____

SOCIAL SECURITY #_____-_____-_____ ID#_____

Employer: _____ Group: _____

Patient Name: _____

Relationship to Patient: _____

IT IS THE POLICY OF THIS OFFICE TO FILE YOUR INSURANCE AS A COURTESY.

I certify that I, and/or my dependent(s) have insurance coverage with the above mentioned insurance, and are assigned directly to DENT-ALL ASSOCIATES, INC. All insurance benefits, if any, otherwise payable from me for services rendered. I understand that I am FINANCIALLY RESPONSIBLE for all charges whether or not they are paid by insurance. I authorize the use of all my signatures on all insurance submissions. Dent-All Associates, Inc. May use my dental care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current dental insurance terminates and/or changes. If payment has not been made by your insurance carrier after your claim has been filed for eight (8) weeks, you will be billed accordingly for these charges. It is then your responsibility to follow up with your insurance company as to the reason no payment has been made. Insurance companies do not guarantee payment on either written or verbal verification. Insurance coverage is a contract between the patient/employer and the insurance company. The dentist does not enter into this contract, thus cannot be responsible for the lack of payment of any assignment. We will be more than happy to assist you whenever possible.

I hereby agree to guarantee and promise to pay the office of Dent-All Associates, Inc. All Charges incurred in the treatment of the above named patient including those expenses not covered by any insurance policy presently in force. All deductable amounts and non-covered expenses are to be paid in full within ten (10) days of notification. If any action of law in equity is brought to enforce this agreement, the office of Dent-All Associates, Inc. shall be entitled to reasonable attorney fees, costs, and any other costs of collections incurred.

SIGNED: _____ **DATE:** ____/____/_____

PRINT: _____ **DATE:** ____/____/_____