ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Payment is due at the time services are provided. Please read and check the appropriate line.

____1) I have dental insurance. I understand that I am required to pay all deductibles and co-pays today for services provided. I understand that the co-payment made today is an estimate only, and that I am financially responsible for any claim not paid by my insurance company within ninety (90) days.

____2) I have Indiana Medicaid. I understand that certain limitations apply and it is my responsibility to inform this office if I have had treatment in another office. I understand if I have a spend down that all or a portion of my care may be my responsibility. I understand if my Medicaid is not in effect today that I am responsible for payment.

____3) I do not have any dental insurance to be filed. I understand that I am financially responsible for all services provided and that payment, in full is due today.

By signing below, I declare that I have read the above statements and agree to be financially responsible for all services provided to me and/or my dependent(s) which are not otherwise covered by insurance or Indiana Medicaid. I understand that this office will invoice me for any unpaid balance on my account and that my account will accrue interest at the rate of two percent (2%) per month following the 1st statement in addition to a statement generation fee of $1.50 per billing statement. If collection efforts are required to collect any portion of my account balance, I agree to be responsible for the payment of all court costs, attorney fees, and any other collection fees associated with the collection process.

x______________________________________ x____________

Print name of patient date

x____

Signature of patient or responsible party