ANDERSON ATKINS DDS

PATIENT FINANCIAL RESPONSIBILITY FORM

Welcome to the dental office of Craig Anderson DDS. 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 our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for 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 copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks - $30.00
    - Missed appointment fee - $40
- By my signature below, I hereby authorize assignment of financial benefits directly to Craig Anderson, DDS. I understand that I am financially responsible for charges not covered by this assignment. I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

Patient Name _____

Patient/Guardian Signature _____

Date _____