Dr David K Skeels, DDS FINANCIAL AUTHORIZATION and ASSIGNMENT OF BENEFITS AGREEMENT

I understand that I will be informed of all treatment and their associated fees prior to initiating dental care. I agree to be responsible for all charges for dental services provided to me or my dependents. To the extent of the law, I consent to the use and disclosure of my personal health information to carry our payment activities in connection with dental insurance claims. **Your insurance policy is a contract between you, your employer and/or your insurance company. If our office is able to accept your insurance company's assignment, it does not absolve you, the patient, of responsibility for the charges in full for treatment rendered**. Our practice will accept an assignment of benefits from your insurance company with the conditions listed below:

- **Initials_____**Although we are willing to complete insurance forms and submit claim on your behalf, Dr David K Skeels office does not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save your time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does NOT eliminate your financial obligation for your treatment. We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.

- **Initials_____**We require you to pay the estimated co-insurance, which is the amount not covered by your insurance company, at the time we provide service to you. The co-insurance is only an estimate of charges and may be found to be insufficient after review by your insurance company. The remaining balance is due at that time.

- **Initials_____**Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, you will be required to pay the entire balance that time. You will be responsible for seeking reimbursement from your insurance company at that time. **You have the option of being reimbursed directly from your insurance company. If you choose to do so, all fees will be due at the time of service.**

- **Initials_____**Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

- **Initials_____**Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments, made or not made by your insurance company to our practice. Furthermore our office does NOT guarantee that your insurance company will pay for treatment you receive from our office. **If your claim is denied, you will be responsible for paying the full amount at that time. **It is ultimately your responsibility to provide our office with your dental insurance information, and to resolve any type of dispute over payments, made or not made, by your insurance company.**

- **Initials_____**Patients with no dental insurance are responsible to pay for services in full at the time treatment is rendered, unless prior arrangements have been made. All emergency dental services or any dental services performed without previous financial arrangements, must be paid at the time services are performed.

- **Initials_____**If full payment is not received within 30 days after service date, **a 5% late fee will be charged to your account balance. (except insurance processing) An additional 5% fee will be applied every 30 days thereafter.**

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGMENET OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

Print Name of Patient or responsible Party Signature of Patient or Responsible Party Date

CANCELLATION / NO SHOW POLICY

Please give us a minimum of 48 hours' notice to cancel your appointment. We do understand things happen. This is why we will allow you to cancel without the 48 hours' notice two times per calendar year. After using those two cancellations at no charge and fail to give us at least a 48 hour cancellation notice, we will apply a cancellation fee of $50.00. This is not covered by insurance and we be required to be paid prior to scheduling additional appointments in our office.