Dr. William Seefried, D.M.D.
2183 SE Ocean Blvd.
Stuart, Fl. 34996

Insurance Agreement

The following office information and policies are outlined to create a better understanding of the use of your insurance benefits.

1. Our office agrees to submit your insurance claims to your company.

2. You must provide us with an up-to-date proof of insurance card and all necessary information to enable us to file your claim.

3. Your responsibility at the time of service includes payment of deductibles, and estimated co-payment.

4. We will bill you if there is any difference in your balance after receiving payment from your insurance company. Any credit over $10.00 will be refunded to you; otherwise it will be credited to your account.

5. Any balance, after payment from your insurance has been received, is due immediately, and will be subject to a delinquent charge if not paid within 30 days.

6. We will be glad to submit a "pre-determination" of benefits to your insurance company so you will have an idea of amount of coverage you have for a particular dental service. However, by signing this form, you agree to be responsible for payment of any dental services provided by us regardless of whether your insurance company covers the service, and for any reason they may deny coverage.

7. You are giving us authorization to release your dental records, including x-rays, to your insurance company.

8. You are giving us authorization to receive payment from your insurance company for dental services provided by us.

9. Our obligation to you is to provide competent, caring dental treatment to the best of our abilities. We expect you to show up for your scheduled appointments, and to cooperate with our treatment instructions. Failure to show up for an appointment, or giving us less than 24 hours notice of cancellation is not respectful of our time, and will result in a $45.00 charge. Subsequent appointments will not be scheduled until this charge is paid. Repeated missed appointments and last minute cancellations will result in dismissal as a patient from this practice.

_____ _____

Date Signature