Insurance Policy and Assignment of Benefits (for patients with dental insurance only)

As a courtesy, we will file the forms necessary to see that you receive the full benefits of your coverage.

Because your insurance policy is a contract between you, your employer, and the insurance company, it

is your responsibility to make sure we have accurate and up to date insurance carrier information,

restrictions of your policy, and billing information. If your insurance company has not paid your claim

in full within 60 days the remaining balance will automatically become patient

responsibility._____initials

Please be aware some and possibly all of the services provided may Not be covered by your

insurance provider. Services, which are not covered, downgraded or fall under L.E.A.T (least

expensive alternate treatment) by your insurance are your responsibility. Any balance left unpaid

after 30 days will be sent to collections, these accounts will accrue a $35 delinquency fee in

addition to any past due balance._____initials

I hereby authorize my primary and/or secondary insurance company to make payments

directly Mt.Pleasant Family Dental. Furthermore, I have read and understand the

Insurance Policy for Mt.Pleasant Family Dental. I agree to abide by these policies.

Patient/Guardian

Signature:_____

Printed Name: _____

Date:_____