Patient Financial Responsibility Form

Premier Family Dentistry

1. **Individual's Financial Responsibility**
    - I understand that I am financially responsible for my dental insurance deductible, coinsurance, or non-covered services.
    - Co-payments are due at time of service.
    - If my dental plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the cost of all services provided.
    - If I am not insured, I agree to pay for the dental services rendered at the time of service.
2. **Insurance Authorization**
    - If you have dental insurance, we will be happy to file claims on your behalf as a courtesy. Therefore, it is very important that the correct insurance information is provided at the time of the patient's appointment.
    - If the information changes, it is the patient's responsibility to notify us at the earliest convenience. While we do our best to verify dental benefits prior to your appointment, this does not guarantee coverage or payments to our office.
    - We do accept direct payments from most dental insurance companies; however, it is a relationship between you, your employer, and the insurance company.
3. **Authorization to Release Records**
    - I hereby authorize Premier Family Dentistry to release my records to my insurer or any other referred dental specialist responsible for my dental care.

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Signature of patient, or authorized responsible party **Date**

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Print name of patient, or authorized responsible party **Date**