LAKEVIEW FAMILY DENTISTRY, P.A.

We are committed to providing you with the best possible care, and we are more than happy to file your insurance for you, however, all co-pays must be made at the time services are rendered. This does not include companies that send payment directly to the insured and not the doctor. Please realize that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. If your insurance pays less than we anticipate, you as the patient are responsible for all remaining balances unpaid by your insurance company. We will estimate as closely as possible without a predetermination of benefits, your coverage, but until we actually receive payment from your insurance company, it is just an estimate, not a guarantee of payment or amount of co-payment.

We accept payment in the form of cash, personal checks, MasterCard, Visa, American Express, and Discover. First time emergency patients must pay by cash or credit card until they are an established patient in our practice. There will be a fee of $25 for all returned checks. A fee as high as 10% of your balance may be accessed if your account becomes delinquent and requires additional collection services. Lakeview Family Dentistry can also help secure financing with approved credit.

I authorized Lakeview Family Dentistry to release any necessary information in effort to collect from my insurance company, and accept assignment of benefits. I, the patient, parent or guardian am responsible for the co-payment or deductible at the time of service, as well as, any remaining balance not paid by my insurance company. I will notify the doctor of any changes in my medical history.

On occasion, it will be necessary for the doctor to take photographs to insure that we attain the highest quality dentistry possible. I give permission to the doctor to use my pictures to supplement my medical records, as well as, any future use in an educational forum. It is understood that any such publication or presentation, I shall not be identified by name.

I have read and I agree to the terms outlined.

Patient Name:_____

Signature:_____ Date:_____

Relationship:_____