

# PLEASE READ CAREFULLY

Dear Patient,

Our office will assist you in submitting *your* insurance forms to *your* insurance company. However, it is the patient's responsibility to pay for treatment and to deal with the Insurance company if the claim is disputed and/or denied.

Please note that if professional services have not been paid by your insurance company within **90 days**, *you* are responsible for payment. A service/financial charge of 1 1/2% per month will be added to past due balances.

**Signing this form indicates your understanding of this agreement, and accepting the responsibility to guarantee payment for services rendered to you if your insurance company does not pay for these services.**

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Patients Name

Date