NEW PATIENT FORMS
FINANCIAL RESPONSIBILITY

Many patients have a commonly held misconception that dental benefit policies, either purchased by their employers or an individually purchased plan, will pay for all their treatment. This is incorrect and untrue.

As a patient in this office, you will receive a treatment that is specific to the problems that are noted during your initial examination. Your doctor will carefully review her findings with you and explain to you the treatment options, if any, that are available to you. In return, your financial responsibility for this treatment will be to the doctor's office. We will be glad to assist you in obtaining reimbursement for part of these benefits from your insurance provider.

Please understand that your benefits contract will always have an "allowable benefit" payment for each procedure provided. This "allowable" is determined by the limitations of the contract that your employer or the individual has purchased from the company and does not always equal the doctor's submitted fee. The insurance carrier will pay a percentage of the "allowable" with a co-payment portion assigned to the patient. You are then responsible to the doctor for payment of your yearly deductible (if not already satisfied), the patient co-payment portion, and any remaining portion of the doctor's bill that is not covered by your insurance plan.

Please understand that insurance payment does not guarantee payment even though you may feel that you have the coverage. Financial responsibility for services you receive at the office is yours alone. We will gladly work with you to arrange payment for services provided, and these arrangements will be set up on an individual-needs basis.

Also note if you need to change or cancel your appointment, please provide a 48 business hour notice. If we do not have advance notice there may be a broken appointment charge applied to your account.

Thank you for your confidence in our office. We look forward to providing you with competent care and courteous service.

Sincerely,
Dr. Day and Staff

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO DR. DAY FOR ALL CARE AND SERVICES PROVIDED TO ME.

Patient Name:_____ Date:_____

Signature:_____ Witness:_____