INSURANCE AGREEMENT

Dr. JEFF CALDWELL
FAMILY DENTISTRY
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To our patients who are requesting that this office carry a balance on their account, to be paid by an insurance company. This information applies to all dental insurance plans, in or out-of-network.

This form must be read and signed by the patient or responsible party before we can accept payment directly from the insurance company.

1.- I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to pay within 90 days, I will be responsible for the full amount.

2.- I understand and agree that this amount estimated to remain unpaid by insurance is to be paid by me during treatment.

3- .I understand that this office cannot make a total accurate estimate of the insurance benefits to be paid for me, since it does not have access to all insurance company records.

4.- I understand that after the insurance company pays, there could be a balance still remaining to be paid by me, this includes in-network insurance.

5.- I understand and agree that if upon payment by the insurance company, there is a remaining balance, it is due to be paid in full by me at that time, and this also applies to in-network insurance companies.

6.- I understand and agree that if the estimate of insurance benefits indicates a large amount due by me, I can request a written financial agreement (terms to be discussed at that time.)

7.-I understand and agree that monthly financing can be obtained when I apply and qualify for Care Credit.

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Signature of Responsible Party Office Manager

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Date