Patient Name: _____ Date: _____

Insurance and patient portions are ESTIMATES ONLY and are provided only as a courtesy,

NOT A GUARANTEE OF PAYMENT.

Please initial the following:

_____ I hereby authorize the release of information to my insurance company. I authorize, if necessary, the dentist/office to request a review of, and or pursue an appeal with my insurance company claim determination.

_____I understand that my insurance company does not cover cosmetic procedures covered by alternate treatment benefits (i.e., Partials vs. bridges, amalgam vs. composites (white) fillings, etc.) Additional surgical parts, lab upgrades and/or utilization of the laser in the form of troughing may apply pending treatment starting at $100-$200 per unit, pending complexity of case.

_____In the event that your insurance carrier does not pay for treatment or pays less than the estimated amount, you agree and understand that you are responsible for the unpaid balance. It is your responsibility to know and understand any limitations with coverage offered by your carrier/employer.

_____After filing your insurance claim and NO payment has been received; YOU WILL BE RESPONSIBLE for those charges assessed to your account.