FINANCIAL RESPONSIBILITY

Many patients have a commonly held misconception that medical and dental benefit policies that their employers, or they individually, have purchased will pay for all of their treatment. THAT IS INCORRECT AND UNTRUE.

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

Often insurance companies, upon the patient's request, will send benefit reimbursement directly to the doctor's office. Please understand that your benefits contract will always have an allowable benefit payment for each procedure performed and that allowable benefit is determined by the limitations of the contract that your employer or you personally have purchased from the insurer and does NOT always equal the doctor's submitted fee. Your insurance plan will pay only a percentage of the allowable benefit your employer or you have bought as part of your plan with a co-payment portion then being assigned to you. You are responsible to your doctor for payment of your yearly deductible, if not already satisfied; the patient co-payment portion; and any remaining portion of your doctor's bill that is not covered by your insurance plan.

We will be happy to discuss with you financial arrangements for the payment of your bill, whether or not you have medical/dental insurance available to you. Please understand that third party payment is NOT a guarantee of benefits payment, even though you may feel that you have the coverage under your insurance policy(-ies). Financial responsibility for all services received at this 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.

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

I HAVE READ THE ABOVE FINANCIAL RESPONSIBILITY STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO BENNINGTON DENTAL CENTER FOR ALL CARE AND SERVICES PROVIDED TO ME.

Patient Name (PRINTED) _____

Date _____

Signature _____

Parent or Guardian Signature (if applicable): _____

Witness _____