FINANCIAL RESPONSIBILITY FORM

If patient is under the age of 18, name of individual who is financially responsible for Minor Patient:

Print Name: _____

For your convenience, we gladly accept cash, checks and American Express, Visa, MasterCard and Discover Credit Cards. We also offer no cost or very low cost Health Care Financing through Care Credit.

If you have dental insurance, we will file the claims for you, as a **complimentary** service. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes it is the patient's responsibility to inform the office.

While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Keith W. Cowhey, D.D.S. We do accept payments from most dental insurance companies; however, the insurance contract is between you, your employer and the insurance company. Payment for co-pays and/or deductibles are due at the time services are provided.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. California Law states that we are not allowed to accept "only what the insurance pays" as full payment.

If requested, we will provide you with a verbal **estimate** of your out of pocket expense for any treatment planned by the doctor and hygienist.

The mouth, gums and teeth are constantly changing due to the progressive nature of dental disease. The actual costs of dental treatment differ from the estimate due to our treatment of this progressive disease. In the event the actual costs of dental treatment differ from the estimated costs, you will be responsible for any additional cost. Every effort will be made to notify you if this occurs.

However, please understand that these are strictly **estimates** and are and are not a guarantee that your insurance company will reimburse us/you based upon these estimates.

All expected insurance balances remaining unpaid after 60 days from the date of service becomes the immediate responsibility of the patient and/or account holder.

Unless prior arrangements have been made, any balance aged beyond 60 days will be subject to interest charges of 1.5% per month, from the date of service, until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, additional collection fees will be applied to any unpaid balance. Any attorney or collection fees incurred due to delinquency in payment or collection efforts will be charged to you, including court costs and fees. **Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $25.00 NSF check fee.**

Changes to all of our schedules occur, however, we kindly request a **48 hour** cancellation notice for scheduled appointments. **A cancellation fee of $100 – $250 may be charged if a 48 hour notice is not given.**

I acknowledge having read this Financial Responsibility Form in its enterity and agreed to be bound by all the terms and conditions herein.

Patient (or responsible party) Print Name: _____

Signature: _____ Date: _____