Insurance Information & Acknowledgment Form

Dental Arts of Bedford

PLEASE READ CAREFULLY

PATIENTS WITH INSURANCE:

Patients who carry insurance are expected to pay a percent of the fee, or the entire fee, at the time services are rendered. Any estimate of your co-payment or deductible, given by *Dental Arts of Bedford* staff, is merely an ESTIMATE. We submit our patient's insurance claims as a courtesy to our patients. However, once a claim has been filed, and payment has not been received from the insurance company after 60 days, the remaining balance becomes the patient's responsibility. (Should the insurance company make payment to *Dental Arts of Bedford* after the 60 days, a refund will be made to the patient for that remaining balance). Should questions or concerns arise, we encourage our patients to maintain open communications with their insurance company to ensure a satisfactory conclusion. By signing below, you are accepting full responsibility for any charges incurred through our services, and agree to pay in-full the balance remaining following Insurance payment.

PATIENTS WITHOUT INSURANCE:

Payment in full is expected at the time of service. We accept credit card payments, cash, as well as personal checks. (Please note that our policy requires a $25.00 fee on all returned checks). We also offer ***CARE CREDIT*** which gives our patients the option to pay their bills in monthly installments. If you have any questions, please feel free to ask, we will be happy to answer them. *Fees are subject to change without notice.*

BY SIGNING BELOW, I AFFIRM THAT I HAVE READ & UNDERSTAND MY RESPONSIBILITY WITH REGARDS TO PAYMENTS FOR SERVICES RENDERED AT DENTAL ARTS OF BEDFORD.

PATIENT NAME *(Please Print)* _____ DATE _____

PATIENT SIGNATURE _____
IF PATIENT IS A MINOR, RESPONSIBLE PARTY'S SIGNATURE.

** Patients must sign this form in order for us to proceed with the treatment process. A Refusal to do so will require us to deny treatment.*