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1084 South High Street, Columbus, Ohio 43206 • Phone 614-444-0417 • Fax 614-444-1091

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### **GENERAL FINANCIAL POLICY**

If you have dental insurance, we want you to receive the full benefit. Our office staff will assist you in completing your insurance forms and verifying the coverage that your particular insurance plan provides. We accept assignment of your insurance payment, another service to you. You are responsible for any applicable deductible amounts and the portion that your insurance does not cover. Please be advised that although our office will make every effort to accurately estimate what your insurance will pay, this does not, in any way, guarantee actual payment from your insurance company. You will be financially responsible for the account, should your insurance plan(s) not honor financial benefits for any procedure(s) rendered.

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with rendering appropriate dental care and further authorize and consent to the doctor choosing and employing such assistance as she deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or her staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items sent via email or mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

I hereby attest that I have read the above section and understand it completely.

Signature of Patient/Guardian\_\_\_\_\_

Date\_\_\_\_\_