IMPORTANT: READ CAREFULLY!
DENTAL INSURANCE COVERAGE NOTICE AND DISCLAIMER

1. I understand and agree that if this dental office does not represent my dental insurance company that this office cannot make ANY representation or warranty that my dental insurance company will cover all or any portion of the dental services provided by this office.

2. I further understand that I will be billed and will be responsible to pay for any and all amounts not paid or covered by my dental insurer.

3. I realize that such bills will include amounts incurred from deductibles, co-payments and amounts not paid by my dental insurer due to exhaustion of my benefits.

4. I acknowledge that it is my ultimate and sole responsibility to determine whether a dental service, procedure or treatment program is covered by my dental insurer and if covered, the amount of coverage that will be provided and whether my benefits are exhausted or will be exhausted during the service, procedure or program.

5. I also acknowledge and understand that this office will not, as a matter of policy, agree to halt any service, procedure or treatment program solely because of my dental insurance benefits have become exhausted and I certainly understand that this office cannot know at what point in my procedure or treatment my insurance benefits will exhaust.

6. I confirm that no representation has been made to me by anyone in this office that is contrary in any way to the above notice and disclaimer.

7. I further confirm that any statement made by anyone in this office concerning my dental insurance coverage cannot be relied on as a guaranty of coverage.

After reading this Notice and Disclaimer concerning my dental insurance coverage I have signed and dated below.

Patient/Responsible:_____

Date:_____

Print name:_____