Faubl Family Dentistry

John R. Faubl, D.D.S.

Our office is most happy to complete and submit most insurance claims forms. Please keep in mind that most insurance companies **do not cover all** dental expenses. We encourage you to discuss any questions you may have regarding your specific plan with our office management. Questions regarding your dental care should be discussed with your doctor. Thank you for the opportunity to serve you.

Please read and sign below showing you have understood the following:

I understand that my insurance policy may not cover all dental services and that it is my responsibility to call my insurance company to verify my/my family's coverage on dental procedures to be performed on me/my family.

My insurance plan may have a deductible which is due at the time of service. I understand that I will be responsible for any other balance not paid by my insurance company.

Any Flex Plan reimbursement will be paid directly to me upon submission of my paid receipts to my company.

I accept full responsibility for all fees required for my child's/children's dentistry, regardless of my marital status.

I understand that if my check payment is returned as NSF from the bank, there is a **$25** NSF charge which will be added to my account, and I may be asked to make payment by credit card, money order, or cash only.

I understand that I am responsible for any reasonable fees, expenses, or costs related to the collection of any unpaid balance, including but not limited to late charges, referral costs, and commissions paid to attorneys or collection agencies.

I understand that there will be a 25% annual interest rate charged on the patient's outstanding balance after the first 30 days with a minimum of **$3** charged per month.

If my insurance company fails to pay my claim in **60 days,** I will pay my balance due in full. Faubl Family Dentistry will provide any copies of claims or x-rays that I need to receive my benefits from my insurance company.

_____ _____

Patient Signature Date