FLACK AND STONE

DENTAL AND MEDICAL INSURANCE NOTICE

In order to prevent any misunderstanding about Dental and/or Medical Insurance, we encourage you to discuss fees and insurance coverage with us prior to any dental or medical procedure. Payment is due at the time services are rendered unless other arrangements have been made prior to treatment. In addition, we wish our patients to know:

1. All dental and medical services are charged directly to the patient, parent, or guardian, not the insurance company.

2. Payment for services rendered in the amount of $350.00 or less will be due the day service is performed.

Our office will prepare the necessary reports and forms to assist you in collecting benefits from your insurance company. If the insurance company makes payment directly to us, then your account will be credited these amounts**. It must be understood that dental and medical services are not rendered on the basis that the companies will pay any or all of our charges.** Each fee charged is the responsibility of the patient, parent, or guardian. In certain instances, if insurance has not processed / paid a claim after 90 days, the balance will be due in full.

I hereby authorize the attending provider to release any information acquired in the course of treatment. I understand and agree that I am ultimately responsible for the account for any professional services rendered.

Signature of patient, parent, or guardian: _____ Date: _____

I will be paying today by: Cash_____ Check_____ Credit Card_____

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance coverage, please read and sign below unless making payment in full.

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. Flack or Dr. Stone. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by any insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient, Parent, or Guardian's Signature _____ Date: _____