LOEFFLER-PITT DENTAL ASSOCIATES, P.C.
FINANCIAL RESPONSIBILITY – ACCOUNTS WITH INSURANCE

TO EACH OF OUR PATIENTS:

Please read the following so that you become aware of our financial policy regarding insurance. Please sign below so that we can be assured you are well informed.

I agree that I am responsible for any and all fees incurred on my account. I am requesting that Loeffler-Pitt submit to my insurance carrier as a service to me. Whatever monies are received from my insurance carrier will be applied to my balance.

I also agree that, should monies be sent to me from the insurance carrier, I will forward that amount to Loeffler-Pitt upon receipt.

I understand that I can request a payment plan if one is needed and that I will follow that plan.

Unless a written payment plan is in place, I understand that fees are requested at the time of service or within 30 days. If after 90 days my insurance carrier portion has not been received by Loeffler-Pitt, I agree to pay that portion as well. If and when Loeffler-Pitt receives any payments, I will be reimbursed.

_____
Name of Patient Responsible for Account

_____
Signature

_____
Date