Statement of Patient Financial Responsibility

Date:

Last Name: First Name: Birthdate:

This is a statement of our financial policy. You understand that you are obligated to ensure that JRivas office's fees are paid in full. If insured, the office will do all the effort to verify your coverage and bill your insurance carrier on your behalf. If insured, you agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan.If you did not set-in in advance a pre-pay plan with our office, you are ultimately responsible for payment of your bill at the time of service.
Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage and it may occur that amount estimate may increase. You are sole responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance of the service redeemed.
Note that sometimes insurance carriers send a check to the patient in order to pay for the dental services redeem in the office, please send or bring this check to us to consolidate your account dues.

ACKNOWLEDGEMENT:
I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including but not limited to, co-payments, deductibles, and amounts due for insurance non-covered, services that are not payable or payment denied by my insurance.

I acknowlege and agree with my finantial resposibilities

- ☐ Yes
- ☐ No