

DENTAL ASSOCIATES OF CEDAR RAPIDS

319-363-0267

Patients who carry Health Care Insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Even though we assist you by filling out the insurance form, this office cannot and does not accept responsibility for collecting your insurance claim or for negotiating a settlement in a disputed claim. You, the patient, have full responsibility for payment of the services in accordance with the established policy of this office. Your coverage will be determined by your insurance carrier and your provider.

Prior approval is always recommended when claims may be disputed and Dental Associates of Cedar Rapids cannot determine when claims may be disputed.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize my treatment or treatment of the patient and have to the best of my knowledge correctly completed the medical history form. I agree to pay all fees and charges for such treatment the day they are incurred, unless prior arrangements are made. I understand that any outstanding balance is due within 28 days of the first billing. Beyond that, a finance charge may be added. We reserve the right to make credit inquiries.

SIGNATURE _____ DATE _____