Dr Kenza Dental Care

NOTICE TO INSURANCE PATIENTS

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS:

A. **Treatment goes over my maximum;**

B. **Insurance benefits have been utilized elsewhere;**

C. **I am not eligible for insurance when services are rendered;**

D. **I prevent or delay payment by not complying with requests for insurance forms or signatures;**

E. **I do not complete my treatment and it results in non-payment by the insurance company;**

F. **Lab costs are incurred due to missing appointments;**

G. **Lab modifications;**

H. **I receive my insurance check and do not send it to your office.**

I have read and understand my obligations in acceptance of my dental insurance as payment.

Signed:_____ **Date:**_____

(Patient or responsible party)