Patient Financial Responsibility Agreement
(Rev. 1/2/2017)

Patient Name: _____ Date: _____

This letter is to inform you that Hines Family Dentistry may or may not participate with your dental plan. We will submit any claims to your dental plan, but you will be responsible for any remaining balance for all services rendered. It is important for you to understand that your procedure(s) may or may not be reimbursable by your insurance depending on your plan.

What you need to do now:

- Read this notice so you can make an informed decision about your care.
- Ask us any questions that you may have after reading this.
- By accepting and signing this document, you will be financially responsible for all services rendered.
- I understand that office visit charges are payable on the day services are rendered.
- I authorize Hines Family Dentistry to bill my insurance company for such services.
- This agreement is between Hines Family Dentistry and myself.

Financial Agreement: I agree in return for services provided to the patient by Hines Family Dentistry, that I will pay my account at the time services are rendered. It is fully understood that the undersigned/patient is primarily responsible for the payment of my bill. Signing below means that I have received and understand this notice.

Patient Name *please print:* _____

Guarantor Name (if patient is a minor) *please print*:_____

Patient or Guarantor signature: _____ Date: _____