SAPPHIRE
DENTAL
PLLC

Your understanding of our financial policies is an essential element of your care and treatment.

Our office policy requires that your bill (or **estimated** insurance co-payment) be paid **at the time treatment is rendered.** Please be advised that insurance companies do not determine our fees. We will be happy to help you **estimate** your co-payment based on the information provided to us by your insurance company, and we will file your claim for you. **We cannot guarantee that your insurance company will pay any or all of your charges.** In the event that your insurance company pays you directly, we ask that you pay for your visit in full and be reimbursed by your insurance company. We will accept **Cash, Check, Visa, MasterCard, Discover, American Express and Care Credit.** A courtesy 5% discount may be given for pre-payment in full 3 days prior to appointment for treatment of $500.00 or more if paid by check or cash.

In all cases, balances remaining after insurance has paid will be billed to the patient. If you have any questions, please discuss them with our office staff. Charges not paid within 30 days will have a service charge of 1.0% (annual rate), or a minimum of $1.00 added to the past due balance.

I understand that I am ultimately responsible for the entire fee and agree to be responsible for any charges not paid by my insurance company. Collection fees will apply to accounts that are sent to collections. By signing below I agree to pay any and all collection fees and attorney fees that would be incurred if my account were to be removed for collection.

This signature is my authorization for the release of information necessary to process my claim and for release of payment of any insurance benefits to Sapphire Dental PLLC.

INSURANCE INFORMATION:

Primary:

Name of Subscriber: _____ Birthdate: _____
Employer: _____ SSN: _____
Insurance Company Name: _____ Phone #: _____
Group #: _____ ID# _____

Patient Printed Name:_____**Date:** _____
Signature of Patient/Guardian: _____