Notice to insurance patients

I understand that I am responsible for my balance with Wackford Dental, including under the following circumstances:

- Procedure was denied due to plan limitations.
- I am not eligible for insurance
- Benefits have been maxed out for the year.
- Procedure covered at different co-insurance rate. (Percentage)
- The insurance benefits are less then what was indicated on the fee schedule provided by your insurance company.
- Waiting periods instilled by the insurance company for new enrollees, which were not disclosed.
- Deductible applied to preventative services.
- I prevent or delay payment by not complying with the request for insurance forms and signatures.
- I do not complete my treatment and it results in non-payment by my insurance company.
- I receive my insurance check and do not send it Wackford Dental.

Understand that we will be happy to help you make the most of your dental benefits and assist you in understanding them. When a claim is submitted and benefits are determined, we have little influence over your coverage.

I HAVE READ AND UNDERSTAND THAT I AM FINANCALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE COMPANY.

Signed: _____ Date: _____
(Patient or responsible party)

Signed: _____ Date: _____
(Wackford Dental Employee)

WACKFORD DENTAL

Parkview Professional Center 9045 Bruceville Road Suite 160 Elk Grove, CA 95758

Ph: 916-683-3841 ▪ Fax: 916-683-3848 ▪ Web: www.wackforddental.com