BAY AREA ENDODONTICS, LLP

RODNEY L ANTHONY D.M.D., PA
CHRISTOPHER L. ROSS, D.M.D., MS., PA

IF YOU HAVE DENTAL INSURANCE:

The responsibility for payment is the patient's, not the insurance carriers. As a courtesy, we will file your insurance claim for you. Unfortunately, there is no insurance company that guarantees payment prior to receiving and reviewing the claim. We will contact your insurance company prior to your appointment to verify your dental coverage. However, the information we receive is only an approximation of what the insurance company will cover. It is ultimately your responsibility to know your insurance policy.

Payment will be collected in full. On the day services are rendered your portion, after any **estimated** insurance payment, is due in full. Financing options for your portion are available through Care Credit, please ask the front office staff for further information if needed.

_____(Patient Initials) I acknowledge that I have read the statement above and I am aware that payment collected at the time of treatment is just an **estimate** pending insurance review and payment.

When your insurance payment is received if it is different than originally estimated, we will either bill you for any remaining balance or send a refund check for any overpayment. To avoid a 1.5% monthly interest rate per month, your unpaid balance would need to be paid in full within 60 days of completion of treatment. In the event you should receive the insurance payment directly, you will need to contact our office immediately. Failure to do so may result in additional fees up and accrued interest charges.

Medical insurance, including Medicare does not cover root canal treatment or surgeries associated with them. In the event of an accident where auto, medical or workman's comp is involved, the patient is ultimately responsible for payment in full at the time of service and will be reimbursed directly from the associated insurance company.

I hereby authorize and direct payment of any insurance benefits to BAY AREA ENDODONTICS, LLP and/or Dr. Rodney L Anthony or Dr. Christopher L. Ross, otherwise payable to me directly. I have read and understand the above and agree to comply.

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PATIENT/GUARANTOR SIGNATURE DATE