Laurie A. Rosato, DMD

FINANCIAL AGREEMENT

We believe in having a strong line of communication with our patients. Our office will help you in every way possible, but you are responsible for understanding your own insurance coverage. We want our patients to fully understand these policies as we feel they are quite fair and you will tool

As a courtesy, we will submit claims to your insurance company; however, you, the patient, are ultimately responsible for any fees that your insurance company should not cover. We are not responsible for negotiating a settlement on a disputed claim. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. IF payment from your insurance company is not received within 60-90 days of service, you will be expected to pay the balance in full. Returned checks and balances older than 90 days will be subject to collection.

- **Patients with insurance:**
  - **For services requiring an insurance co-pay, the co-pay is due at the time of service based on your individual policy.** Please contact your insurance company to learn what your co-pay percentages are. Upon final reconciliation of insurance payment, if the insurance payment is not reflective of what the co-payment was estimated to be, the remaining balance is the patient's responsibility.

- **Patients without insurance:**
  - **Payment in full at the time of service for patients that do not have dental insurance.**

FINANCIAL UNDERSTANDING AND AUTHORIZATION

I understand that the office of Dr. Laurie A. Rosato has not offered me any assurance or determination that my medical/dental insurance will pay for all of my care. I understand that I may ask my insurance company for a pre-treatment estimate of benefits, but that **I remain responsible for all fees not paid by my insurance.** Understanding this policy statement, I accept responsibility to the office of Dr. Laurie A. Rosato for services rendered. I authorize release of any information relating to my dental claims. **I also authorize payment directly to the office of Dr. Laurie A. Rosato of the insurance benefits otherwise payable to me. I authorize Dr. Laurie A. Rosato to provide information from records in this office to doctors or specialists that I may be referred to for treatment.**

In signing this form, **I a also acknowledging receipt of the office of Dr. Laurie A. Rosato's Notice of Privacy Practices (HIPAA Notice).**

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Patient Name

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Patient or Legal Guardian Signature Date