Angel Dentistry
21027 N. Cave Creek Rd
Phoenix, AZ 85024
(602)788-2008

First Name:_____ **Last Name:**_____

Notice To Insurance Patients

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS:

A. **The Treatment goes over my yearly maximum.**

B. **Any treatment is denied by my insurance company.**

C. **I am not eligible for insurance.**

D. **I prevent or delay payment by not complying with requests for insurance forms or signatures.**

E. **I do not complete my treatment and it results in non-payment by the insurance company.**

F. **Lab costs are incurred due to missing appointments.**

G. **I receive my insurance check and do not send it to your office.**

H. **Financial Responsibility:** **I FURTHER AGREE TO PAY ALL FINANCE CHARGES, COLLECTION COST, ATTORNEYS FEES AND ANY OTHER COST THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNT OUSTANTING**

I authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by the authorization. I herby accept the foregoing treatment plan and authorize release of any information relating to this claim.

I have read and understand my obligations in acceptance of my dental insurance as payment.

Signed_____ **Date**_____

Sincerely,
Dr. Amber Angel, DDS