JASON B. COUCH DDS
MODERN DENTISTRY

Acknowledgement of Patient Financial Responsibility

Please read and initial the following

1. I understand that my bill is ultimately ***my*** responsibility._____

2. I understand that knowing the specific benefits and limitations of my dental insurance plan is also ultimately ***my*** responsibility._____

3. I understand the office of Jason B. Couch, DDS will provide insurance benefit ***estimates*** for proposed treatment before it is started. I understand that these are ***estimates only*** and are calculated based on information provided to the office by my insurance company._____

4. I understand that once my insurance claim is closed and they have paid their portion, there may be a resulting balance on my account. I understand that any balance on my account is due in full ***within 30 days*** of the close of the claim or interest will accrue._____

5. I understand it is my responsibility to notify the office of any changes in my insurance coverage prior to treatment so that an accurate estimate can be provided._____

Signature:_____Date:_____

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