VIENNA DENTAL CARE

Financial Policy & Patient Financial Responsibility

Patient Name: _____ **Date:** _____

At Vienna Dental Care, we are committed to providing quality dental care and maintaining clear communication regarding financial responsibilities.

If dental insurance is used, we are pleased to submit claims as a courtesy. Any estimate of insurance benefits provided by our office is based on information available at the time and is **not a guarantee of payment**. Final payment is determined solely by your insurance carrier according to your plan's benefits, exclusions, limitations, deductibles, annual maximums, waiting periods, and allowed fees.

By signing below, I acknowledge and agree that:

- I am financially responsible for all dental services provided.
- My estimated co-payment, deductible, and patient portion are due at the time services are rendered unless other arrangements have been made in advance.
- I am responsible for any balance not paid by my insurance carrier, including amounts resulting from deductibles, co-insurance, non-covered services, benefit limitations, denied claims, annual maximums, frequency limitations, or differences between the provider's fees and the insurance plan's allowed amount.
- Verification of insurance benefits does not guarantee payment.
- I understand that any remaining balance becomes my responsibility after my insurance carrier has processed the claim.
- I authorize Vienna Dental Care to submit claims and receive payment directly from my insurance carrier for covered services.

I have read, understand, and agree to this Financial Policy.

Responsible Party (Print Name): _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Dentist: _____ **Date:** _____