Rock Doc Dentistry
Rene Herrera DDS

NOTICE TO PATIENTS

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

1. The treatment goes over my annual maximum insurance allowance.
2. My insurance company denies any treatment.
3. I am not eligible for insurance benefits.
4. I prevent or delay payment by not complying with requests for insurance forms or signatures.
5. I do not complete my treatment and it results in non-payment by the insurance company.
6. Additional lab costs are incurred due to missing appointments.
7. I received my insurance check and do not immediately send it to your office.

I hereby authorize payment directly to the dentist and or dental group (listed below) of the group dental insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I hereby accept the recommended treatment plan and authorize release of any information related to this claim.

I have read and understand my obligations with regard to the acceptance of my dental insurance as payment.

Patient/Legal Guardian Signature: _____

Witness Signature: _____

Date Signed: _____

Dentist/Dental Group: Rene Herrera DDS