MAMKIN
DENTISTRY
aesthetic & restorative center

Acknowledgment of Financial Responsibility

I acknowledge my understanding and compliance with the following:

1. All payments and co-payments are due at the time of dental treatment.

2. If an arrangement is made for partial cash payments to be paid over the course of multiple visits, each installment is due prior to or at the time of each corresponding procedure. A procedure will not be performed if my account is not current or if an outstanding balance remains.

3. I am fully responsible for payment of all fees for dental services provided to me by Dental Care of Ridgewood, PC.

4. I am responsible for submitting all bills to my insurance carrier, but Dental Care of Ridgewood, PC will do so as a courtesy for my patronage.

5. I authorize Dental Care of Ridgewood, PC and its assignees to contact my insurance carrier for any purpose relating to the payment of claims for dental services.

6. The insurance information I have provided is the most recent and correct information available. I certify that I have valid dental insurance coverage on the date of service.

7. If the insurance carrier denies payment for any reason, I understand that I will be fully responsible for the fees charged by Dental Care of Ridgewood, PC in connection with dental treatment rendered and will pay said amount immediately.

8. If the insurance carrier issues the check directly to me for dental services performed by Dental Care of Ridgewood, PC, then it is my responsibility to pay said amount to Dental Care of Ridgewood, PC either in cash, money order or by endorsing and transferring the insurance check to Dental Care of Ridgewood, PC.

9. My failure to pay any amount for dental services provided by Dental Care of Ridgewood, PC will result in additional costs, referrals to collection agencies and/or attorney fees, for which I will be responsible.

Signature of Patient_____ Date_____

Signature of Parent/Guardian if Patient is a Minor_____ Date_____