

# **Michael H. Robbins, DDS.**

## **INSURANCE COVERAGE**

Dear Patient,

Verification of your dental insurance coverage at the time of your dental visit is not a guarantee of payment and you will receive treatment with the understanding that as a courtesy, we will bill your insurance company, and if your coverage is not in effect or they do not pay the charges within 30 days you will be billed and held financially responsible for these services rendered.

Person responsible for this account \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Policy Holder's Birthday \_\_\_\_\_

Policy Holder's Social Security Number \_\_\_\_\_

Please note that the information you provide is for insurance verification only and all of the information is confidential and will not be released to any other party.

I have read the above, and understand my possible financial responsibility for services rendered and hereby affix my signature as an acknowledgement of this understanding.

I have read and understand that a co-payment may be due at each visit. **If I should not show up for an appointment, or cancel less than 24 hrs before the appointment, then I am responsible for the co-payment(s) or cancellation fee for the missed visit(s), PRIOR to being seen.**

Patient's Signature: \_\_\_\_\_