

Oakhurst Dental Associates

Dr. Michelle Dlugosz
226 Monmouth Road
Oakhurst, NJ 07755

Responsibility Statement

A note about your insurance:

Your Dental Insurance is a means for you to receive partial reimbursement for fees that you paid to the doctor. **Having insurance is not a substitute for payment.** We will be happy to assist you in receiving payment from your insurance company. Many companies have fixed allowances or percentages based on your contract with them. **NOT with this office.**

It is your responsibility to make sure that we receive FULL payment for all services rendered. This may include, but not limited to; **deductibles, co-payments, and any other balances NOT paid by your insurance at the time of your visit.** Please be sure to provide us with accurate and up to date information so that we may better assist you in getting reimbursed. Often, insurance companies will decline payment for services due to inaccurate information. Therefore, it is imperative that you inform us of any changes in your coverage.

We will assist you in receiving as much reimbursement as possible, but **YOU are ultimately responsible for the entire bill.**

For all cases that must be sent to a laboratory, **the balance must be paid in full prior to delivery of prosthesis.** Also, timely delivery of such prosthesis is imperative. Any unnecessary delays on the part of the patient may necessitate additional work as well as the additional fees.

I, _____, understand that it is customary to pay for services **at the time they are rendered**, and that **I am responsible for the payment of any balances accrued by me.** I also understand that all account balances over 30 days are subject to a 1.9% service charge per month on the outstanding balance. I also understand that if it should become necessary to turn my account to a collection agency, I will be entirely responsible for all legal and collection fees incurred by my account.

Patient or Guardian Signature _____
Date _____