

Angel Dentistry
21027 N. Cave Creek Rd
Phoenix, AZ 85024
(602)788-2008

February 3, 2015

Notice To Insurance Patients

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

- A. The Treatment goes over my yearly maximum.**
- B. Any treatment is denied by my insurance company.**
- C. I am not eligible for insurance.**
- D. I prevent or delay payment by not complying with requests for insurance forms or signatures.**
- E. I do not complete my treatment and it results in non-payment by the insurance company.**
- F. Lab costs are incurred due to missing appointments.**
- G. I receive my insurance check and do not send it to your office.**
- H. Financial Responsibility: I FURTHER AGREE TO PAY ALL FINANCE CHARGES, COLLECTION COST, ATTORNEYS FEES AND ANY OTHER COST THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNT OUSTANTING**

I authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by the authorization. I herby accept the foregoing treatment plan and authorize release of any information relating to this claim.

I have read and understand my obligations in acceptance of my dental insurance as payment.

Signed _____ **Date** _____

Sincerely,
Dr. Amber Angel, DDS