David L. Baker, D.D.S., P.A.

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Plano, Texas 75075

972.612.3920

OUR FEE POLICY: To control costs, we ask our patients to pay for their office visit at the time services are rendered. This office will, as a COURTESY to our patients, file for and accept insurance benefits for services rendered. We allow 30 days for insurance to remit payment.

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I UNDERSTAND that my dental plan may have a deductable for which I am responsible. _____

I UNDERSTAND and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I UNDERSTAND that if my insurance does not pay for the entire procedure, does not pay their percentage completely, or refuses to pay for a particular procedure for any reason, I am ultimately responsible for any balance due. _____

MY account balance is **my responsibility** and is due, in full, 45 DAYS from the date of service regardless of insurance payment status. I will notify you of any changes in my dental insurance.

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ASSIGNMENT OF BENEFITS: I hereby assign all dental benefits to which I am entitled, including private insurance, and any other health plans to: **DAVID L BAKER, D.D.S.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES whether or not paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure the payment. _____

Please read and initial all blank spaces.

SIGNED: _____ DATE: _____