TOSCH DENTAL
118 West K Street. Benicia. CA. 94510
(707) 745-2130

We are pleased to assist you with any dental insurance. If you have dental insurance, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been has been met, or if your coverage table is lower than average.

Patient Financial Responsibilities

- The Patient (or patient's parent or guardian, if under the age of 18) is fully responsible for payment of care regardless of if you have insurance or not.
- As a courtesy to you, we will bill your insurance company for services rendered.
- Some procedures or treatments may not be covered by your insurance plan. Patients are responsible for the payment of all services rendered in this office, with our without insurance.
- Any remaining balance left after the insurance has paid their portion is the responsibility of the patient or their guardian if the patient is a minor.
- You are responsible for taking part in the recovery of your insurance claim. After 45 days, you will be responsible for PAYENT IN FULL for any outstanding balance.
- I am responsible for providing a copy of my current insurance cared to Dr. Tosch's office. If my current insurance is incorrect it is my responsibility to provide that information the day of service. If I fail to provide my insurance information on the day services are rendered or I do not have insurance, I understand that I must PAY IN FULL the same day that services are rendered.

Patient Initials _____

Please read the following statement and sign below

- I acknowledge that I am fully responsible for payment for all treatment I receive in this office. I understand my insurance carrier may deny part of, or not cover, my claim for these services. I understand that providing Dr. Tosch with my insurance information is my responsibility. I understand that my insurance is a contract between myself and my insurance carrier and that Tosch Dental has no part in this contract. I understand the terms of this form and accept full financial responsibility with or without use of dental insurance.

Patient Name: _____

Signature:_____ Date:_____