**Patient Consent for Dental Insurance Verification and Eligibility of Benefits**

I certify that I have received a copy of my Dental Insurance Verification and Eligibility of Benefits. I am aware that I will be responsible for any non-covered procedures/treatment by my insurance company and may receive a Bill for remaining balance after my insurance has been billed. It is my responsibility to pay at the time of service if my insurance does not cover or has Maxed out for the year.

Consent signed for:

1. Received a Copy of my Insurance Benefits during my appointment.

2. It has been reviewed & I understand the Dental Benefit coverage I have.

3. I understand that not all benefits will be covered by my insurance by 100% and I am responsible for the remaining balance.

4. If needing a payment arrangement or if treatment is not paid in full during the time of service, appointments will not be scheduled.

Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_