Patient's Name: _____ Date: _____

(First Name, Middle Initial, and Last Name)

Mekari Dental Studio
Financial Responsibility Notice

Thank you for choosing Mekari Laser Dentistry for you dental needs. Please review the following notice and sign below to indicate you have read, understand and accept responsibility to pay any charges not paid by your dental plan.

1. Unless arrangements have been made in advance, co-payments, co-insurance, and any outstanding balances are expected at the time of service.

2. Any check returned from the bank will result in an additional $25.00 charge that will appear on your account.

3. Patient accounts not paid promptly are subject to third party collections and/or legal procedures.

4. If your insurance carrier has not responded to a claim within 45 days, we reserve the right to formally transfer all associated liability for the claim to you. Failure to promptly resolve this balance may result in third party collection and/or legal procedures to be taken.

5. Your dental insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to your carrier. If you have obtained dental insurance, your insurer may pay some or all of those charges on your behalf, depending upon the coverage you purchased. Pre-authorization by your dental plan is not necessarily a guarantee of payment. Plans review the claim to determine eligibility and benefits for all the services before payment is made.

6. Each dental plan establishes its own rules and definitions of what is dentally necessary or reimbursement by the plan and what is excluded from coverage. This may not be consistent with your expectations or reimbursement from prior visits and may have not been communicated to us or to you before your services are rendered. Accordingly, your dental plan may or may not pay for all services you receive.

7. We will submit a claim on your behalf and advise if your dental plan determines some or all of your care or testing is not eligible for coverage. You are financially responsible for charges your dental plan determines are not covered.

8. A down payment/deposit may be required for all patients interested in reserving an appointment for treatment to avoid missed appointment or less than 24 hour cancellation fees.
We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. Failure to provide sufficient notice will result in a $75.00 fee.

9. Your dental plan may also determine that your plan requirements were not met or that an approved provider of service was not used. You are welcome to receive care or testing, however if your dental plan reduces or denies benefits due to the provider you see is not a participating provider with your dental plan, you will be financially responsible.

10. You are responsible for notifying our office of any change in name, address, phone or insurance information.

_____ _____

Patient/Guarantor Signature Clinic Representative

_____

Date