

## Accountability Confirmation

• **Financial Information** – I understand I am financially responsible for payment in full of all my accounts. I further understand that fees for professional services rendered are payable in full within 30 days. A service charge of 1% per month will be added to all account balances for 60 days old; this is an annual rate of 12%

I understand that if my account becomes delinquent, I may be referred to a third party for collection. I also understand that future dental services may be limited for all persons under my account until my account is current.

\* **Insurance disclosure** – *I understand and acknowledge that it is my sole responsibility to contact my insurance company and/or employer to assure proper approval for services and coverage at Racine Dental Group, S.C.* I understand that my insurance carrier may pay less than the actual fee for services. In order to expedite the preparation, mailing and processing of my insurance, I hereby authorize Racine Dental Group, S.C. to provide the insurance company(s) claim administrator and consulting care professionals information concerning health care advice and/or treatment provided. This information will be used for the purpose of evaluating and administrating claims for benefits otherwise payable to you. I understand and acknowledge that it is my sole responsibility to obtain payment from my third party in the event that my insurance does not pay any balance in full.

• **Release of Information** – I attest to the accuracy of the information within this form and agree to provide Racine Dental Group, S.C. with any changes. I have the right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. Any information obtained will be used for the purpose of insurance filing, payment and collection of fees for services rendered.

This authorization will remain in force and effect until revoked by me in writing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Do not print** (patient or person authorized to consent for patient and relationship)

### **Note to Parent of Minor Children**

Per Wisconsin Statute 766.55, parents of minor children are jointly and severally responsible for any and all balances resulting from services rendered to minor dependents. Dependent children will be placed under the account of the parent or guardian of whom the minor child resides. The parent or guardian with whom the dependent child resides will receive all documentation pertaining to the account such as statements , recall notices and insurance notices.

Racine Dental Group, S.C. does not get involved in domestic disputes such as divorce decrees, parental liabilities, custody, or any other personal family issue. These personal matters are not the responsibility of Racine Dental Group, S.C. Racine Dental Group, S.C. will not provide documentation pertaining to the account to any individual not identified on the reverse except at the request of the account holder.

Thank you in advance for your cooperation