Plantsville Family Dental

Thomas L. DeRienzo, D.M.D.
15 Cornerstone Court
Plantsville, CT 06479

Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstanding and facilitates processing of your insurance claim. If you have any questions, please ask us. Thank you.

Agreement

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 90 days, I will be responsible for the full amount owed to Dr. Thomas L. DeRienzo.

I understand and agree that I am responsible for the estimated amount not paid by the insurance company.

I understand and agree that if upon payment by the insurance company to Dr. DeRienzo there is still a remaining balance, I am responsible for the amount in full at that time.

I understand and agree that if the estimate of insurance benefits indicated a large amount due by me and I feel I cannot pay it during treatment, I can request a written financial agreement (terms to be discussed at that time).

I understand that a monthly late charge of $10.00 or 1.5 % of any outstanding balance, whichever is greater, will be added to my account for every 30 days delinquent. In addition, reasonable costs of collections may also be added to my delinquent account if turned over to a collection agency.

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Signature of Responsible Party **Office Manager**

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Date