Summit Smiles LLC

Insurance/Appointment Agreement

As a courtesy, Summit Smiles will collect as much information as possible regarding a patient's insurance coverage such as effective dates, maximums, deductibles, percentages covered. Ultimately, it is the patient's responsibility to keep track if they have reached their maximum, when their coverage period begins and ends, and what is or is not covered. Insurance does not guarantee any payment to our office until treatment is complete and claims have been received and processed by the insurance company. **All information obtained by Summit Smiles is NOT a guarantee of benefits. The patient is ultimately responsible for payment of all services rendered.**

It is our office policy to collect payment on date of service rendered. We estimate to the best of our knowledge what the patient's responsibility will be at that time. Any difference in that amount will be the patient's responsibility. Insurance claims are submitted by Summit Smiles as a courtesy.

I also understand that should my insurance company send payment to me, I will forward the payment to Summit Smiles within 48 hours. I agree that if I fail to send the payment to the provider, they are forced to proceed with the collections process. I will be responsible for any cost incurred by the office to retrieve their monies. Any violations of this agreement will terminate patient charge privileges with provider and bring any balance owed by patient immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, **or if there is a remaining copay after insurance payment,** I authorize Summit Smiles to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

Providing quality treatment for all of our patients in a timely manner is a major focus of our practice philosophy. If you need to reschedule an appointment please provide us **24 hours notice** and **contact us during business hours.** This will allow us to offer the time to another patient who is in need and waiting. Failing to do so will result in a $50 cancellation fee.

Required*

Account # _____ MC VISA Discover AMEX

Expiration Date _____/_____

CVC (3 digits on back of card) _____

Cardholders Signature _____

Print Name _____Date _____

I AUTHORIZE SUMMIT SMILES TO FACILITATE PAYMENT UTILIZING THIS CREDIT/DEBIT CARD TO RESOLVE ANY BALANCE/CANCELLATION FEE.