General Dentistry Treatment Agreement & Contract

Advanced Dental Group – 3662 Katella Avenue suite 202 Los Alamitos

PATIENT NAME

BIRTHDATE

DATE

If you are using indemnity insurance please be advised that we are estimating what your insurance will pay and what your portion of the cost will be. In the event that your insurance does not pay the estimated amount, you will be responsible for your portion plus any amounts not paid by your insurance and any treatment started and not delivered, I.E– crowns, onlays or any removable appliances.

I understand that my indemnity insurance may not pay the full, estimated amount and that any portion of cost unpaid by my insurance company will be my responsibility. I understand that I am responsible for the full cost on the proposed treatment, although my indemnity insurance will be billed for it.

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me but not to exceed the charges shown above. I understand that I am financially responsible for the charges not covered by this authorization. I hereby accept the forgoing treatment plan and authorize release of any information relating this claim.

I acknowledge that I have received a copy of the material facts sheet dated October 2001.

Signed:___________________________

Date:___________