Patient Financial Responsibility Form

Thank you for choosing CMB Family Dentistry. We are committed to providing the highest quality dental care. Please sign this form to acknowledge your understanding of our patient financial policies.

- We appreciate payment at the time services are rendered and offer payment options for extensive treatment. We accept VISA, MasterCard, AMEX, Discover, and Debit Cards.

For Patients with Dental Insurance:

- Many patients have dental insurance and our office is ready to help you receive your benefits.
- We will submit to your dental insurance company for you, however you are ultimately responsible for payment of the bill.
- Your insurance coverage and benefits are a contract between you and your insurance company. All disputes must be handled between you and your insurance company. We are currently an "In Network Provder" for Cigna PPO **ONLY.** We are an "Out of Network Provider" for **ALL** other insurance companies.
- While we make every effort to assist you with your insurance questions, you must understand that it is your responsibility to know your insurance plan and to know the extent of that coverage.
- Insurance companies are obligated to you, the insured, not to our office. It is often difficult or impossible for us to get information regarding your insurance.

For Patients without Dental Insurance

- We offer a yearly membership plan. Information can be found on our website, or ask any team member for more info.

Patient Consent:

By signing this document, I_______________________________ have fully read, understand and consent to the financial policy of CMB Family Dentistry. I hereby consent to allow CMB Family Dentistry to reach me if needed, concerning any billing questions or concerns. I will cooperate with the billing department to ensure payment for my services In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

Print name of Patient/ Guardian__________________________________

Signature of Patient/ Guardian___________________________________

Date_________