FINANCIAL AGREEMENT

Insurance

MAY RIVER ENDODONTICS files insurance claims and determines policy coverage as a courtesy to our patients. The full portion of a particular dental service(s) is due at the time of service. In addition, you may have an annual limitation for the amount of dental services that can be reimbursed by your insurance company each plan year. You are responsible for monitoring the amount of your remaining benefits for any annual benefit period. While we do our best to provide accurate information to you, please do not rely upon any information provided by MAY RIVER ENDODONTICS regarding your remaining benefit in any such benefit period.

____ please initial — INSURANCE RELEASE: I, the undersigned, certify that I (or my dependent) have insurance coverage, and authorize MAY RIVER ENDODONTICS to submit any and all claims for benefits on my behalf. I authorize MAY RIVER ENDODONTICS to release to any insurance company or other entity responsible for paying such benefits any information necessary for the filing of claims or the determination of eligibility or benefits for services

____ please initial — **ESTIMATE: Before treatment is started, MAY RIVER ENDODONTICS will provide me with the best estimate of what my insurance reimbursement for services will be. I hereby acknowledge that this is ONLY AN ESTIMATE and may not necessarily be the EXACT amount that I can expect to pay for treatment received or services rendered.**

By signing below you acknowledge that you have read the above in its entirety.

____

Patient (or Parent/Guardian) Signature — Date

Patient (or Parent/Guardian) Printed Name