I, ____, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all the charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at the time. As a patient, or responsible party, I agree to pay for all services rendered in accordance with the terms and conditions set forth as stated in the financial policy above. I understand that delinquent accounts may be assigned to a credit reporting collection service and may be charged a collection fee. I herby authorize Pearly Whites Family Dentistry to release information necessary to secure payment. I also herby assign all rights and authorize payment directly to Pearly Whites Family Dentistry any claim filed on the above-named patients behalf.

Signature: ____ Date: ______________________