Acknowledgement of Financial Responsibility

Please initial each individual statement, signifying you understand each statement, then sign where indicated.

_____ I understand that the Kelsey Periodontal Group, LLC and its doctors are not preferred providers or in-network periodontists for any dental or medical insurance companies.

_____ I understand that although they are not preferred providers or in-network periodontists for any dental or medical insurance companies, the Kelsey Periodontal Group, LLC will submit claims to my insurance company as a courtesy to me so I can realize any periodontal / dental benefits from my insurance policy.

_____ I understand that the fee for my consultation appointment is due the day of the consultation appointment. I understand that the Kelsey Periodontal Group, LLC will submit a claim to my insurance company for the consultation appointment, and the insurance payment assigned to the Kelsey Periodontal Group, LLC will be reimbursed to me or credited to my account.

_____ I understand that any subsequent treatment I agree to with the doctors of the Kelsey Periodontal Group, LLC will require a signed treatment plan.

_____ I understand that any pre-treatment estimates of benefit (EOB) from my insurance companies are only estimates, and that if there is a discrepancy where a balance is due, it is my responsibility to pay off that balance within 30 days.

_____ I understand that the Kelsey Periodontal Group, LLC offers a limited variety of payment plans for treatment.

By my initials above and signature below, I acknowledge understanding of my financial responsibility for seeking treatment at the Kelsey Periodontal Group, LLC.

_____

Signature of Patient Printed Name of Patient Date

Kelsey Periodontal Group LLC

PRIMARY DENTAL INSURANCE INFORMATION

PLEASE BE SURE TO NOTE WHO THE PRIMARY INSURED and/or POLICYHOLDER IS AND WHO THE DEPENDENTS ARE ON YOUR INSURANCE CARD. IF THE POLICYHOLDER IS SOMEONE OTHER THAN YOU, THE PATIENT, PLEASE FILL IN THE POLICYHOLDER'S INFORMATION HERE AS IT WILL EXPEDITE ALL INSURANCE CLAIMS. THANK YOU.

Primary Insured's Name: _____
Last First Middle Suffix

Primary Insured's SSN: _____ Insured's Date of Birth: _____

Group Number: _____

Subscriber ID Number: _____

Employer Through Which Benefits Are From: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company Phone Number: _____

SECONDARY DENTAL INSURANCE INFORMATION

Primary Insured's Name: _____
Last First Middle Suffix

Primary Insured's SSN: _____ Insured's Date of Birth: _____

Group Number: _____

Subscriber ID Number: _____

Employer Through Which Benefits Are From: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company Phone Number: _____