Nyffeler's
East Troy Family Dental

Patient's Name: _____ D.O.B: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Please Circle One: Home | Cell | Work Phone #: (_____)_____

Please Circle One: Home | Cell | Work Phone #: (_____)_____

Please Circle One: Home | Cell | Work Phone #: (_____)_____

Email Address: _____

Marital Status: _____ Drivers License #: _____

S.S. No: _____-_____-_____ Employer: _____

Method of Payment: (please circle one): Cash | Check | VISA/MC | Insurance

Who Carries Insurance: (please circle one): Self | Spouse | Parent | N/A

Dental Insurance Carrier: _____ ID #: _____

Group #: _____ If Patient is under the age of 18, name of individual who is financially responsible for Patient: _____

Spouse's Name: _____ D.O.B: _____/_____/_____

Spouse's Employer: _____ S.S. No: _____-_____-_____

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of patient's appointment. If this information changes, it is the patient's responsibility to update East Troy Family Dental at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to East Troy Family Dental. We do accept payments from the dental insurance companies; however, we are not contracted with them. It is a contract between you, your employer and the insurance company.

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If requested, we will provide you with a verbal ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. Please note that any difference in payment from your insurance company and your account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and/or account holder.

Payment for co-pays and/or deductibles is due at the time services are provided.

Any balance older than 90 days will be subject to interest charges of 1.5% per month, from the date of service, until the amount is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, additional collection fees will be applied to any unpaid balance. **Any attorney or collection fees incurred due to delinquency in payment or collection efforts will also be charged to you, including court costs and fees.** Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $15 NSF check fee and may also subject you to court costs and attorney fees.

A cancellation fee may be charged if a 48-hour notice is not given.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

_____ Date: _____/_____/_____

Signature

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