Dr. Brandon Ellis Dr. Jeffrey Rubino Dr. Kevin Dooley
19638 Leitersburg Pike, Suite 103
Hagerstown, MD 21742
301-739-1100/301-739-1900

STATEMENT OF FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship.

Our office submits claims to the insurance company a courtesy to our patients. All co-pays and deductibles are expected to be paid at the time of service. Your insurance claim will ONLY be completed and submitted if we are provided with all pertinent insurance information. It is YOUR RESPONSIBILITY to verify that your policy is in force on the date of service. Insurance is an agreement between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurances, "usual and customary" charges, etc., other than to supply necessary factual information.

If you do not have insurance, we expect payment in full for all treatment at the time of service. You are responsible for prompt payment of your account.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my dentist to release information necessary for my course of treatment. I also authorize the release of medical or other information necessary to process my insurance claims.

Name: (print)_____

Signature of Patient or Parent: _____

Date: _____

AGREEMENT

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that a monthly Finance Charge of 1.5% may be added to my account if my balance is not paid in full within 90 days. If my account becomes excessively past due and is referred to a collection agency, the fees associated with the agency will be added to my balance.

Responsible Party Signature: _____