AMY PHILLIPS, D.M.D., L.L.C.
PEDIATRIC DENTISTRY
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PEDIATRIC DENTISTRY
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INSURANCE AUTHORIZATION & BINDING FINANCIAL AGREEMENT

Providing the best possible dental care involves a mutual understanding between patient and provider. The professional services provided to your child (children) are based on what we determine to be necessary or recommended – and ***not*** determined by what insurance plans will or will ***not*** cover. Ultimately, payment for our services is **YOUR RESPONSIBILITY**. Should you have any questions regarding the following policies, or about your specific insurance plan, please ask the office staff for assistance.

Please read the information below regarding our office policy for payment for provided dental services:

- I authorize the office of Amy Phillips, D.M.D., L.L.C. to release any information regarding my child's (children's) care, to expedite claims or for records transfer, should such events be required.

- I hereby authorize the office of Amy Phillips, D.M.D., L.L.C., to bill my insurance company for services provided to my child (children) and assign payment to be made directly to the office of Amy Phillips, D.M.D., L.L.C., and that such authorization is valid until written notice is provided to cancel that authorization.

- While the office of Amy Phillips, D.M.D., L.L.C. makes considerable efforts to verify my insurance coverage, benefits, and cost shares, I understand that such information is NOT an official or legally binding estimation of my out of pocket expenses. Ultimately, my final cost share is dependent on the decision of my insurance carrier. **I UNDERSTAND THAT ANY COST SHARE ESTIMATES GIVEN TO ME PRIOR TO MY CHILD'S (CHILDREN'S) DENTAL VISIT MAY TURN OUT TO BE DIFFERENT FROM THE FINAL DECISION OF MY INSURANCE CARRIER, AND I AGREE THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO AMY PHILLIPS, D.M.D., L.L.C. FOR PAYMENT OF ALL CHARGES, INCLUDING ANY AMOUNT IN EXCESS OF PREVIOUS COST SHARE ESTIMATES.** I realize that if my insurance company fails to pay its anticipated benefit in full or payment is not made within 60 days, it is my responsibility to pay for the services provided, and that I will pay collection fees, attorney's fees, court costs, etc. for the purpose of collection on delinquent accounts.

- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the office of Amy Phillips, D.M.D., L.L.C..

- I understand that there is a $30 fee for all returned checks. Accepted payment methods are: cash, check, Visa, MasterCard and American Express.

- I understand that cost share estimates for dental treatment are due at the time services are rendered and that my estimated out of pocket responsibility amount is expected to be paid in full by the last treatment visit. If the courtesy of payment arrangements are extended after treatment has been completed, I understand and agree that the established payment amount is due each month.

I understand and agree to all statements made herein and understand that this is a legally binding agreement.

Signature:_____ Date:_____
(Parent or legal guardian)