SECONDARY INSURANCE PROVIDER INFORMATION

Insurance Provider **Address, City and Zip Code**

Group Number **Subscriber Number** **Date of Birth**

Responsible Party **Social Security Number** **Date of Birth**

Name of other dependents covered under this plan

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY. IF YOU AGREE TO THE TERMS OF THE FINANCIAL POLICY, PLEASE SIGN AT THE BOTTOM OF THIS PAGE.

The San Francisco Dental Office routinely processes and submits patients' dental insurance claims as a professional courtesy. To expedite insurance claims processing, we need complete and accurate information. Any changes in employment and or/insurance carriers must be provided to us in writing.

I understand that the determination of effective or termination dates is my responsibility. However, I understand that all charges incurred are my responsibility. And I, not the insurance company, am ultimately responsible for payment in full for all services rendered. At the time of treatment. I agree to pay the **estimated** portion of any fees that are not covered by my insurance plan. Unless at the time of treatment I have paid my balance in full, I agree to forward to the San Francisco Dental Office any payments (and supporting documents) that may be sent to me by my insurance provider and will forward said payments within seven days of receipt. Due to insurance policy changes and/or necessary changes in any treatment plans, insurance coverage may vary from any estimated treatment plan provided by San Francisco Dental Office. I understand that all services are due to be paid in full within sixty days of the date of service, whether my insurance benefits have been received. If my account balance is not paid in full within sixty days from the date of service, an interest charge of 1.5% per month (18% per annual) will be levied against my account.

I understand and agree to the above insurance/financial policy. In addition, I herby authorize Yvette Danielle Marquis, D.D.S. to sign and submit insurance claims on my behalf. I understand that this authorization will assign all insurance benefits directly to the San Francisco Dental Office.

Signature **Date**