# WEBER PROFESSIONAL DENTAL CORP.

**27450 Tourney Rd, Suite 270**
**Valencia, CA 91355**
(661) 254-3700

**Please Initial Below:**

_____1. I understand I am financially responsible for the **TOTAL CHARGES** of dental services. I understand that your office will bill my dental insurance as a courtesy to me. I further understand that if for **ANY REASON** my insurance / insurances **DO NOT** cover any charges, I will be **FULLY** responsible for the charges incurred.

_____2. I understand that I am responsible for any remaining balance after your office receives payment from my insurance carriers.

_____3. I understand my remaining outstanding balance beyond 90 days from Treatment will bear interest of 1.5% per month or 18% per year.

_____4. In addition, I understand that if collection proceedings are pursued by your office, I will be responsible for any and all applicable collection fees.

_____5. When an appointment is missed without 24 hours notification, you will be charged a $25.00 fee. We need 24 hours to make arrangements for someone else to fill that time slot. We confirm your appointments the day before but it is ultimately your responsibility to remember the appointments you have set.

We communicate with your insurance company to verify benefits. We can estimate what your patient's portion would be for procedures you might need. However, other factors such as calls to the insurance member services and/or computer on line information may be incorrect and do not constitute a guarantee of coverage. Therefore keep in mind, these are "Estimates Only". Benefits are determined upon receipt of actual claims for dental services. It is your responsibility for knowing the provisions and limitations of your policy. You are responsible for any payments or fees your insurance does not cover.

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**Please Print Patient's Name**

_____ _____
**Patient, Parent or Guardian's Signature** **Date**