May 1, 2012

Notice of Financial Responsibility

As of the date of this letter, the dental practice of Robert A. Claypoole, DMD, PC is requiring that all patients read through this financial notice and sign acknowledging their understanding of our policy.

- Each patient is responsible for providing us with proof of their dental insurance.
  X_____ Initial

- We accept most insurance plans however we do not accept HMO plans.

- We will submit and process all dental claims. Certain procedures may not be covered by your insurance or, payment may be a partial payment paid by your insurance company. In both cases you are responsible for any balance. Our office will inform you of your "out of pocket" responsibility. If there is a co-pay, you as the patient are responsible for payment at time of service plus any deductable.

- If for some reason there is a balance on your account, we will send you a statement at the end of the month in which your dental work was completed. Full payment is expected is expected within 30 days of the billing statement. If payment is not received, we have the right to access a $29.00 late fee for each month not paid in full.
  X_____Initial

- If you are unable to pay for your dental work, we can assist you with a special financial plan. This plan is not available for all clients, however we can discuss your specific situation.

We appreciate your business and look forward to continuing to provide high quality dental service to you and you family!

By signing below I acknowledge that I have read the above notice and agree to these terms.

X_____Date_____

Print Name _____