OVERMEYER
FAMILY DENTAL

I hereby authorize the release of any information required to process my (or my dependants) dental insurance claims. I understand that I am fully responsible for payment of any fees not paid for, for any reason by the insurance company. I understand that I am fully responsible for payment of any fees due to failure to provide this office or the insurance company any required information needed to process my (or my dependents) claims. I, hereby authorize payment of my insurance benefits directly to Overmeyer Family Dental.

***I understand that I am responsible for total fee for treatment regardless of insurance.**

****As a courtesy to our patients, we gladly file with your insurance company. *PLEASE NOTE THAT ALL ESTIMATES GIVEN ARE ROUGH ESTIMATES, processing insurance is not a guarantee of payment. YOU ARE ULTIMATELY RESPONSIBLE FOR THE ENTIRE TREATMENT FEE.*****

Due to the nature of services received there will be no refunds or returns accepted.

_____ _____

Patient's Signature (parent/guardian of minor under 18) Date

Tear & keep for your records.

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