Mark T. Bentley DDS, Charles H Stevens DDS
1523 North Market Street
Troy, Ohio 45373
1-937-335-4630
1-937-335-5174 fax

Mark T. Bentley DDS, Inc.

Financial Obligation for Patients Without Dental Coverage

I am not covered by any dental insurance and understand that I am responsible for payment in full at the time of service.

I understand that by signing below, I agree to the above statement concerning my financial obligation with Mark T. Bentley DDS, Inc.

_____ _____ _____
PLEASE PRINT PATIENT'S NAME *SIGNATURE OF RESPONSIBLE PARTY* *DATE*

Financial Obligation for Patients With Dental Insurance Coverage

I am providing my dental insurance information to Mark Bentley DDS, Inc. so that they may bill my dental insurance company (as a courtesy to me) for their services. I understand that I am responsible for charges to my insurance company until those charges have been paid in full. I also understand and agree to the following.

1. Mark T. Bentley DDS, Inc. will submit a bill for their services to my insurance company based on the information that I have provided.

2. Mark T. Bentley DDS, Inc. will provide my insurance company with the information that it needs in order for my claim(s) to be processed in a timely manner.

3. I am responsible for verifying that Dr. Mark Bentley and or Dr. Charles Stevens are recognized as covered providers by my insurance company before services are rendered. I understand that I will be responsible for any penalties imposed by my insurance company if Dr. Mark Bentley or Dr. Charles Stevens are not on my insurance plan.

Please remember that your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance." The Financial obligation for your dental treatment is between you and this office, and is not between the insurance company and us.

I am responsible for and I agree to pay all co-pays, co-insurance and deductibles that are not covered by my insurance. **I understand that my estimate may be inaccurate if dental work has been done in another dental office. I understand that any legal fees incurred by this office in collection of my balance, will be my responsibility.**

I understand that I am financially responsible for charges that have been denied by my insurance company immediately **upon the first denial of those charges by my insurance company regardless of the reason the claim(s) is/are denied.**

I understand that by signing below, I agree to the above statements in order to ensure timely processing and payment of my bill with Mark T. Bentley DDS, Inc. I further understand that a copy of this statement will be provided to me upon my request.

_____ _____ _____
PLEASE PRINT PATIENT'S NAME *SIGNATURE OF RESPONSIBLE PARTY* *DATE*

I REFUSE TO SIGN THIS FORM. I DO NOT WISH TO HAVE INSURANCE FILED BY THE OFFICE OF MARK T. BENTLEY DDS, INC. I AM AWARE THAT I AM TOTALLY RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.

_____ _____
SIGNATURE OF RESPONSIBLE PARTY *DATE*