Morristown
COSMETIC DENTISTRY

Payment Responsibility

I understand that payment is due and payable at the time services are rendered, unless prior financial arrangements have been made with the office in advance. I further understand, if applicable, that my dental insurance is a contract between the insurance carrier, and me, and not between the insurance carrier and Dr. Victor Gittleman.

I am fully responsible for all dental fees.

Any payments received by Dr. Victor Gittleman from my insurance carrier will be credited to my account, or refunded to me if I have paid the dental fees incurred. In the event my account is referred to a collection agency or attorney I will be responsible for any reasonable collection fees and/ or legal fees.

This signed affidavit also acts as approval agreement of assignment of benefits for all insurance fees not paid by myself at time of dental service. I understand and request that all benefits requested by Dr. Victor Gittleman be paid by my insurance carrier directly to Dr. Victor Gittleman.

Dr. Gittleman will request benefits be paid directly to the office in the event that I have any outstanding insurable balance. This approval is not intended to act as sole payment for services. My balance is my responsibility.

APPOINMENTS ARE RESERVED JUST FOR YOU, PLEASE PROVIDE 24 HOURS NOTICE BY PHONE OR WE WILL RESERVE THE RIGHT TO CHARGE A CANCELLATION FEE.

_____
Patient Name Please Print

_____ _____
Patient Signature or Account Responsible Party **Date**
Over 18 years