PATIENT NAME: ____

TO ALL OUR PATIENTS:

Our office policy is to have payment at time of service. I recognize that I am responsible for charges incurred today.

DATE ____________ SIGNATURE ____________________________

I recognize that Dr. Taylor's office policy requires a 48 hour notice to cancel an appointment without incurring a fee.

DATE_____________ SIGNATURE_____________________________

****

PATIENTS WITH INSURANCE COVERAGE:

This office recognizes how difficult it is to understand the specifics of today's insurance policies and will work with you to obtain the maximum benefits available. Please be aware that some, and perhaps all, of the services provided may be non-covered services or not considered "reasonable and customary" under your dental insurance policy.

It must be understood, however, that the contract is made between the insurance company and the patient. Therefore, it becomes the **patient's responsibility for knowing the details of coverage.**

In the event a service is rendered that is not covered by my insurance company, I will be financially liable for this dental service. I also understand that my copayment and deductible are due at the time service is rendered.

DATE_______________ SIGNATURE___________________________________

****

I hereby authorize payment of the dental benefits otherwise payable to me directly to Keith A. Taylor, D.D.S. P.A.

DATE_______________ SIGNATURE_____________________________

****