ROCKCASTLE
FAMILY DENTAL CENTER

PATIENT RESPONSIBILITY FORM

1. Individual's Financial Responsibility:

- I understand that I am financially responsible for my dental insurance deductible, coinsurance or non-covered service.
- Coinsurance and deductibles are due at the time of service.
- In the event that my dental plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the dental services rendered to me at the time of service.

2. Insurance Authorization for Assignment of Benefits:

I hereby authorize and direct payment of my dental benefits to **Rockcastle Family Dental Center** on my behalf for any services furnished to me by the providers.

3. Authorization to Release Records:

I hereby authorize **Rockcastle Family Dental Center** to release to my insurer, governmental agencies, or any other entity financially responsible for my dental care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other dental provider.

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Signature of Patient/Authorized Representative Date

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Print Name of Patient/Authorized Representative Relationship to Patient