



PATIENT FORMS

Financial Responsibility & Insurance Acknowledgement

At Orange County Prosthodontics, we are committed to helping our patients maximize their dental benefits. As a courtesy, our office may assist with verifying your insurance coverage and submitting claims on your behalf. However, please understand that:

Insurance Verification

Any insurance information we obtain is provided directly from your insurance company. Our verification of benefits is only a courtesy and not a guarantee of payment.

Final determination of coverage and payment is made by your insurance carrier after services are rendered and claims are processed.

Patient Responsibility

You are responsible for knowing the details of your insurance plan, including deductibles, co-payments, annual maximums, limitations, and exclusions.

If your insurance company denies payment, pays less than expected, or does not cover certain services, the remaining balance is your responsibility.

Payment for all treatment not covered by insurance is due in full by the patient/guarantor.

Financial Agreement

By signing this form, you acknowledge that you are financially responsible for all charges incurred for services provided by our office, regardless of insurance coverage or payment.

You agree to promptly pay any balance not covered by your insurance plan.

Medical Debt Credit Reporting Notice

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency.

In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Acknowledgment and Agreement

I have read and understand the above policy. I acknowledge that any insurance information provided by the office is a courtesy and does not guarantee payment. I agree to be fully responsible for all charges for dental services received, regardless of my insurance coverage or benefits.

Signature

Date