Dr. Daniel Skotzko
Family, Cosmetic & General Dentistry

CONCERNING INSURANCE

As a courtesy, we will assign a staff person to assist you in attempting to verify your dental insurance coverage, determine the limitations of your policy, identify your maximum dental insurance benefits, and assist you with filing the necessary forms, so that you receive the benefits to which you are entitled.

There is no guarantee of insurance coverage or payment. You should be aware that your dental insurance company does not guarantee payment, does not cover all procedures, and may not pay for any dental services provided.

By signing below, you acknowledge that you have been fully informed in advance of receiving treatment that your insurance may deny payment for some or all of the dental services that may be recommended and provided by Dr. Skotzko. You agree to be responsible for payment in full for charges, including "Covered Services" denied coverage by your insurance.

INSURANCE INFORMATION

Patient Name _____ Relationship to Policy Holder _____

Patient Date of Birth _____ Patient Social Security # _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Social Security #_____ Employer _____

Insurance Company _____

Group #_____ ID #_____ Phone #_____

Insurance Company Address _____

City _____ State _____ Zip Code _____

❑ **I do not have dental insurance.**

_____ _____

Signature of Patient or Guardian Date