LA CHOLLA DENTAL GROUP

2040 W. Orange Grove Rd. #160

Tucson, AZ85704

Patient Name: ___________________________________ DOB: _________________

Notice To Insurance Patients

I understand that I am responsible for my balance with La Cholla Dental,
Including under the following circumstances:

A. The treatment goes over my insurance company's yearly maximum benefit.
B. My insurance company denies treatment.
C. I am not eligible for insurance.
D. The insurance benefits are less than what was indicated by La Cholla Dental's Estimator.
E. I prevent or delay payment by not complying with requests for insurance forms and signatures.
F. I do not complete my treatment and it results in non-payment by my insurance company.
G. Lab costs are incurred due to my failure to appear to my appointments.
H. I receive my insurance check and do not send it to La Cholla Dental.

I HAVE READ AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE.

SIGNED: ____ DATE: ________________

(Patient or Responsible Party)

____ DATE: ________________

(Print Patient or Responsible Party's Name)