Wellington Center for Laser Dentistry
Marisol Lopez-Belio D.D.S.

Patient Name: ______________________________________

Statement of Financial Responsibility

Wellington Center for Laser Dentistry appreciates the confidence you have shown in choosing our practice for your dental needs.

Our practice is a fee-for-services practice, and we are **NOT associated with any dental insurance company. Furthermore, we are NOT providers under any PPO / HMO or other insurance plan. It is your responsibility to ensure payment in full of your fees.**

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

Many insurance companies have stipulations that may affect your dental coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to Wellington Center for Laser Dentistry. I authorize my insurer to pay any benefits directly to Wellington Center for Laser Dentistry and, I agree to pay the full and entire amount of all bills incurred by me or the above named patient, if applicable, of any amount due after my insurance company has paid their part.

Signature: ____

Printed Name: ____

(relationship to patient: self - guardian - other: __________) Date: __________