



FISHER & ZITTERICH
FAMILY | COSMETIC | IMPLANT
DENTISTRY

INSURANCE AGREEMENT

We strive to provide our patients with optimum dental treatment in the most comfortable and caring environment, and we make every effort to help our patients receive the maximum benefits from their insurance company for our services. To help us accomplish this for you, it is necessary that you provide us with complete and correct insurance information so filing your claim can be handled promptly and accurately.

We are not affiliated with any discounted dental insurance networks as they seek to compromise *our* quality for the sake of increasing *their* profits. However, as a courtesy to you, we will file your insurance claims based on the information provided to us by your insurance company, and estimate what your portion will be. **Your estimated portion is due at the time services are provided.** We have found that insurance companies are more apt to pay in a timely manner if you are more involved with the handling of your claims, since the actual relationship is between you and your insurance company. They are responsible for paying your claims within 60 days. If their payment is delinquent, it is then respectfully your responsibility to pay your remaining balance.

I acknowledge that I have completely read the above statement and hereby agree that I am responsible for my outstanding balance not paid by my insurance company.

Patient's Name: _____ Date: _____

Patient's Signature: _____