Dear Patient,

At Sorriso Dental we value our patients and we want to continue serving our community with the best possible care. In order to achieve these goals, we need your assistance and understanding of our payment policy. Our hope is that any misunderstandings can be avoided.

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient, and the patient is responsible to Sorriso Dental for payment of services. Due to constantly changing insurance contracts between your employer and insurance companies, benefits and deductibles, we are only able to approximate your dental benefits coverage. While we do our best to know accurate yearly dental benefits maximums, sometimes we are not accurate for things such as if you have used dental benefits at other offices, changed plans, etc. At Sorriso Dental we care about the treatment that you need and will always focus on what is best for our patients. Therefore, if you should exhaust your maximum yearly dental benefits with any dental insurance provider you will be responsible for the balance.

As a courtesy to you, we will file your insurance claim at no additional charge. If the insurance company pays less than expected, you will be responsible for the difference. In the event of a denial of a dental claim, we will provide you all of the necessary documentation for the appeal process, upon request.

Payment for estimated patient portions are due at the time the services are rendered. We accept Cash, Check, Visa, MasterCard, American Express, Discover, and CareCredit as a form of payment. A fee of $25 will be assessed on returned checks.

If your insurance company does not reimburse Sorriso Dental for serviced rendered within 60 days, you may be responsible for the balance in full.

Quoted treatment fees are honored for a period of three months and may be subject to change thereafter.

If you have any questions about the above information or any uncertainty regarding your dental benefits coverage, please do not hesitate to ask. We are here to assit you.

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Patient, Parent, or Guardian Signature Date

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Patient Name (Please Print)