MARK A. STRANDBURG
DMD
FAMILY AND IMPLANT DENTISTRY

Payment Responsibility Form

Patient Name: _____ Date: _____

We are pleased to assist you with your dental insurance. If you have dental insurance, please be aware that insurance quotes are an ***estimate only***. Estimates are based on the limited information your insurance carrier provides to us. Actual costs may be more or less depending upon insurance coverage. I understand that I am responsible for any portion of the dental treatment fee that insurance does not cover. Dr. Strandburg's office will collect this estimated co-pay at the time of treatment and will bill me for any additional amount I owe if insurance benefits are less than estimated. Failure to do so may result in further collection action.

I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

_____ _____

Patient/Guardian Name Date

_____

Patient/Guardian Signature