Canton Heights Dental
Dr. William B. Klausmeyer, DDS, PC

Insurance Disclaimer

(Please read carefully)

Please note we do not accept nor participate with any DMO/HMO insurance plans, prepay plans, Medicaid or discount plans.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an **estimate** of what your insurance coverage will be, it is not a guarantee. If you need **exact** payment of benefits, then a pretreatment is required. If you would like this done, you must specify to the office manager **before** any work is initiated. **(This takes 6-8 weeks).**_____(Initial)

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay within **120 days** of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check. Also remember dental insurance plans are not designed to cover all of your dental needs.

I,_____, have chosen to allow Canton Heights Dental to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within **120 days** of my date of service then I will become responsible to pay at that time.

Print Name:_____ **Date:** _____

Patient Signature: _____

Staff Signature: _____

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Photo/Video Release Form

I,_____(please print), grant permission to Canton Heights Dental and its agents and employees the irrevocable and unrestricted right to reproduce the photographs and/or video images taken of me, or members of my family, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium. I hereby release Canton Heights Dental and its legal representatives for all claims and liability relating to said images or video. Furthermore, I grant permission to use my statements that were given during an interview, with or without my name, for the purpose of advertising and publicity without restriction. I waive my right to any compensation.

I acknowledge that I am [ ] over the age of 18

[ ] the legal guardian of the following

If legal guardian of minor(s), please list name(s) here:

Name(s):_____
Signature:_____Date:_____
Address: _____