Harvard Dental Group
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FINANCIAL RESPONSIBILITY FORM

I, _____, understand that as a patient and/or member of an insurance plan that some services that I receive will require a co-payment and/or may not be covered at all under my insurance plan. As a reminder: treatment is not diagnosed based on insurance coverage; but rather on the dental need(s) of each individual patient. The amount of a particular co-payment, etc. will vary according to the particular insurance plan and/or the procedure being performed.

I further understand that I am ultimately responsible for any and all charges incurred regardless of insurance coverage. Any insurance benefits quoted are not a guarantee of benefits, but rather an estimate based on the information provided by my insurance carrier. I am aware that I am responsible for any charges not covered by insurance carrier, regardless of benefits quoted.

In addition, I have been made aware that Harvard Dental Group does have a 48 hour cancellation policy. Therefore, any appointments missed and/or not cancelled with at least 48 hours advance notice will be subject to a $50. Broken Appointment Fee.

_____ _____
Patient's Name (Print) Parent/Guardian's Name (Print) *(if applicable)*

_____ _____
Patient's or Parent/Guardian's Signature Date