THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

THE OHIO STATE UNIVERSITY COLLEGE OF DENTISTRY
PATIENT INSURANCE VERIFICATION AND FINANCIAL RESPONSIBILITY AGREEMENT

Insurance Verification and Assignment

I certify that the information I have provided about my active dental and/or medical insurance coverage is correct to the best of my knowledge.

I authorize the release of any dental/medical records or other information including the diagnosis and treatment rendered to me, as requested by my dental and/or medical insurance carrier.

I authorize the assignment of benefit payment(s) from my insurance carrier(s) directly to the College of Dentistry and to the practitioner who provided service(s) to me.

Financial Responsibility

I understand that payment in full is expected at time of my appointment if I do not have a dental insurance carrier that the College of Dentistry is currently contracted with. I understand that I am responsible for paying estimated co-pays, deductibles, and co-insurance payments at the time of appointment for insurance carriers that are currently contracted with the College of Dentistry.

I understand that if I come to the College of Dentistry on the day of my appointment without one of the acceptable forms of payment listed below, the College of Dentistry has the right to reschedule my appointment.

I understand that any lab services or dental products made specifically for me will require a 50% down payment. I understand that this payment is due before the products or lab services will be ordered for me and that this payment is non-refundable. I understand that a delay in my payment could result in a delay in receiving my products or lab services.

Patients who have dental and/or medical insurance benefits:

I understand that I am directly responsible for all payments and financial obligations for any services that I receive at the College of Dentistry. I understand that the College of Dentistry will attempt to gain as many benefits as possible from my insurance carrier(s) for the services provided to me. I understand that there is no promise or guarantee of payment or coverage from my insurance carrier(s) for the services provided to me. I understand that it is my responsibility to pay any balance due after insurance processing, and/or insurance payment. This payment must be made in the full amount within 30 days.

Payment Options

Accepted methods of payment: Cash, Check (established patients only), Visa, MasterCard, American Express, Discover, and Flexible Spending Credit Cards.

MEDICAID PATIENTS: I understand that I must present my current Medicaid identification card at the time of each appointment. I also understand that after Medicaid has processed the claim, there may be a portion of the bill remaining. I understand that any remaining balance will be my financial responsibility. I agree to pay this remaining balance within 30 days.

MEDICARE PATIENTS: I understand the College of Dentistry is NOT a Medicare Contracted Provider. I understand that this means services completed at the college CANNOT be submitted for payment to Medicare. I understand that I am responsible for any and all fees charged to me during my appointment for the services I received and that my payment is due at the time of my appointment.

Patient Name	Patient/Parent/Legal Guardian/Representative Signature