FULL DENTAL
Notice to Insurance Patients

Patient Name_____

Member Name: _____

Insurance Name: _____

Insurance ID #: _____

I understand that I am responsible for my balance with Full Dental, including under the following circumstances:

- The treatment goes over my insurance company's yearly maximum benefit.
- My insurance company denies treatment.
- The insurance benefits are less than what was indicated on Full Dental's Estimator.
- I do not complete my treatment and it results in non-payment by my insurance company.
- Lab costs are incurred due to my failure to appear at my appointments.

I have read and understand my obligations when using my dental insurance as payment or partial payment for my treatment.

_____ _____

Signature of Responsible Party Date