Stockton Family & Cosmetic Dentistry, P A.
5219 Two Notch Rd
Columbia SC 29204

FINANCIAL AGREEMENT

I understand that Stockton Family &Cosmetic Dentistry will make every effort to help me get the maximum benefit from my insurance plan(s).

However, I also understand that Stockton Family &Cosmetic Dentistry cannot guarantee that every item billed to my insurance(s) will be covered by the plan(s).

I further understand that the staff of Stockton Family Cosmetic Dentistry will gladly answer any questions I may have about coverage issues before services rendered.

Finally, I understand that insurance usually does not pay for any service in full and that my plan(s) may not cover some services at all. I also agree to pay any co-pay at time of service and any co-insurance and deductible. I understand that I am responsible for any amount left on my account after my insurance has paid.

Name of patient: (Print) _____

Signature of patient, Guardian or Legal rep: _____

Date: _____

Phone: (803) 735-9446 | Fax: (803) 735-9813 | Email: stocktondentistry@hotmail.com