



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 are rendered.

Finally, I understand 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 ultimately responsible for my bill, including any amount left on my account after my insurance has paid.

Name of patient (Print): _____

Name of patient (Signature): _____

Date: _____