O'Leary Dental Office
Dr. Kevin S. O'Leary

Patient____

Address____

Insurance
Carrier____

Payment & Financial Responsibility

My insurance carrier is here by requested and authorized to pay directly to **O'Leary Dental Office** for any service rendered.

Further, I agree to pay **O'Leary Dental Office** the difference, if any, of the agreement between the insurance carrier and O'leary Dental Office. It is my responsibility to pay any deductible and/or coinsurance that are remaining after my insurance company has issued payment and/or denial.

It is further understood that I, the undersigned agree to pay **O'Leary Dental Office** the full amount of charges should my treatment be such that is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

O'Leary Dental Office will file the billing information in a timely manner, unless otherwise instructed by the patient or primary insured.

Furthermore, I agree that if for any reason I cancel my appointment with O'Leary Dental Office

I will be charged a FIFTY-FIVE dollar ($55) fee, if an appointment is:

- Cancelled the DAY OF APPOINTMENT
- Cancelled less than 48 hours prior to appointments.
- I do not show up for scheduled appointment.

This fee will not be covered by your insurance company**.**

By signing below, I agree that I have read this financial agreement between myself (the patient) and **O'Leary Dental Office** and understand the financial agreement.

Date________________________

Signed________________________________

Witness_______________________________

REVISED 01/01/2017 JD