MESSINGHAM ORTHODONTICS

INSURANCE AGREEMENT

Thank you for choosing **Dr. Jason A. Messingham** for you Orthodontic treatment. As a special service to you, we plan to assist you in the filing of your Orthodontic insurance. We accept your insurance benefits as a courtesy to you and to lower your monthly payments to us. This allows you more financial freedom of paying only your portion. In relieving you of this financial burden, we allow ourselves to be very vulnerable to the insurance company. Therefore, we have guidelines and limitations which must be recognized and followed.

We cannot be held responsible for knowing all the peculiarities and requirements of all insurance companies. It is your responsibility to be familiar with your particular insurance plan and benefits. We will not be held responsible for any remaining balances not covered by your insurance. Any unpaid amounts will be transferred to your account and you will be held responsible.

If at any time you have a change in your insurance benefits, change of carrier, change of employer or loss of benefits you must notify us immediately and provide a new insurance carrier card or new filing information. If you neglect to notify us of any such changes we will apply the remaining balance to your account and we will average that amount into your monthly payments remaining.

If at any point in time the insurance company sends a payment directly to you, you must bring it into our office or send it directly to us. Do not deposit and reissue us a check. Any attempt to withhold insurance benefits will result in immediate termination of insurance agreement and we will hold you responsible for the remaining balance of the payments due.

If for any reason the insurance company becomes uncooperative, we reserve the right to refuse to work with the insurance company. And you will be held responsible for the remaining balance.

When the end of treatment is approaching, if the insurance company has not paid the entire benefit available, we will hold you directly responsible for the unpaid balance prior to the removal of the orthodontic appliances.

I understand the agreement in which I will abide by the requirements and limitations set forth. I will abide by the requirements and limitations set forth. I hereby authorize insurance assignment to **Dr. Jason A. Messingham, DDS, MS**.

_____ _____

Signature of Responsible Party Date

Insurance of Responsible Party:_____

Address Provided:_____