Cox and Patel DDS

326 N. Indian Hill Blvd
Claremont, CA 91711
909-626-1684

NOTICE TO OUR PATIENTS

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS:

A. The treatment goes over my yearly maximum.
B. Any treatment that is denied by my insurance company.
C. I am not eligible for insurance.

I hereby authorize payment directly to the above named dentist of the group benefits otherwise payable to me.

I understand that I am financially responsible for any changes not covered by this authorization. I hereby release any information relating to this claim.

I have read and understand my obligation in acceptance of my dental insurance as payment.

Signed_____Date_____