PERSONAL GUARANTEE

PLEASE READ CAREFULLY!

The office of Dr. Gregg R Kolebuck offers patients the courtesy of filing insurance claims on their behalf. However, due to the complex nature of dental billing, it sometimes become necessary to seek payment directly from the patient. The Agreement is designed to outline both parties' responsibility in the collection process and assure the office of Dr. Gregg Kolebuck receive full payment for services and material rendered. **This is a legal binding contract and shall be enforced with the laws of the State of Nevada.**

Office Responsibilities:

1. The office of Dr. Kolebuck shall use reasonable efforts to correct and timely file insurance claims on my behalf for the services and materials rendered.
2. Claims shall be tracked by trained staff members to minimize processing times.
3. The office shall promptly respond to request from insurance carriers for additional information in order to minimize processing time.
4. Upon written request, the office shall provide documentation of all collections efforts.

Patient Responsibilities:

Failure to abide by any term of this agreement may result in termination of the claim filing process; all fees becoming due and payable immediately.

1. Patient agrees to provide complete and accurate insurance information at the time services are rendered. **Failure to do so may result in termination of the claim filing process; all fees becoming due and payable to the office of Dr. Kolebuck immediately.**
2. Patient agrees to respond to all requests for additional information needed to process a claim within 48 hours of receiving such notice. **Failure to do so may result in termination of the claim filing process; all fees becoming due and payable to the office of Dr. Kolebuck immediately.**
3. Patient agrees to notify the office of Dr. Kolebuck of any changes to address or telephone number occurring within the claim processing period. **Failure to do so may result in termination of the claim filing process; all fees becoming due and payable to the office of Dr. Kolebuck immediately.**
4. Patient agrees to pay in full any and all outstanding after 120 days from the date of service regardless of the reason for denial or delay of payment.

I understand I am ultimately responsible for all charges incurred regardless of whether my insurance company pay claims filed on my behalf. The undersigned hereby agrees to abide by this **Personal Guarantee.**

_____ _____

Patient Signature (Guardian Date

LAKE SAHARA DENTAL
INSURANCE AND BILLING POLICY

Thank you, for choosing our office for your dental health needs. We are committed to providing you with the highest quality dental care in a relaxed and comfortable atmosphere. Please understand that payments of your bill is considered integral to our treatment plan and dentist/patient relationship. The following is a statement of our Insurance and Billing Policy, which we require you to sign and date prior to treatment.

IF YOU HAVE DENTAL INSURANCE

Lake Sahara Dental currently accepts all private care dental insurance plans. (Plans that do not require you to select a dentist from a provider list or require our office to accept a reduced fee for services). Our office is also a preferred provider for: Cigna, Delta Dental, Diversified Dental Services, MetLife, The Preferred Dental Network and other PPO plans. Please be aware some services may not be "covered service" under certain insurance plans, however, may be quite necessary or advisable for your care.

Although we maintain computerized payment histories from a given insurance company, benefits change often. Therefore, it is impossible to provide you with exact benefits quotes at the time of services. As a courtesy, we **estimate** your deductible and co-payment amounts based on the most up-to-date information available to us, but this is **ONLY AN ESTIMATE. We require payment in full of your estimated portion of the charges or any non-covered charges at the time of service.**

- If your insurance company requires a pre-authorization for your visit, we will make every effort to obtain one for you but it is **your responsibility** to make sure your pre-authorization is in place. It is also your responsibility to make sure that we are a participating provider. **Initials: _____**
- You are responsible for your bill; insurance companies are billed as a courtesy to you. After 60 days from the date of service, you will be responsible for payment in full. You are entitled to collect the insurance benefits that are due to you. If your insurance is delinquent, denies payment, or applies the amount to your deductible, you are responsible for the outstanding balance. Should this account become delinquent you are responsible for any and all legal fees, court costs, late fees and collection charges involved as a result of collection activity, plus 25% interest.
  Initials: _____

Should your insurance company pay an amount less than the estimated insurance portion, you are responsible for the balance, and if it pays more than your estimated portion, you will be issued a refund for any credit balance on your account.

Financial Information

We accept MasterCard, Visa, American Express, and Discover. **Balances past due over 60 days will be assessed a finance charge of (18%) APR.** Balances past due over 90 days may be referred to an outside collection agency in which case a collection fee will be assessed. There is a $50.00 service charge for all returned checks for "Insufficient Funds". **Initials: _____**
If a dental appointment is cancelled without providing at least 24-hours prior notice (not valid if left on voice mail. Must talk to office), a cancellation fee of $50.00 for missed hygiene appointments and a minimum of $100.00 for missed appointments with doctor. **Initials: _____**

Financial Policy

The undersigned hereby agrees that in consideration of services to be rendered, that the patient or legal guardian individually, jointly and severally obligates himself, herself or themselves to pay the account to Gregg R Kolebuck, D.D.S. Ltd.
I understand that financial obligation is my/our responsibility as the patient/guardian and, should the insurance company deny payment or I/We on payment arrangements, the undersigned agrees to pay reasonable attorney fees and collection expenses should the account be referred to a third party for collections.

_____ _____

Patient or Guardian Signature Date