



Jeremy S. Kato, D.D.S.

Financial Agreement and Insurance Disclaimer

All payments are required at the time of service, unless other arrangements are made in advance.

As a courtesy to you, we will bill your insurance. However, any estimate of charges and insurance payments are subject to modification depending on unforeseen or un-diagnosable circumstances that may arise during the course of treatment. It is understood that the patient/responsible party agrees to be fully responsible for payment of services regardless if benefits are denied in whole, or part, to eligibility or plan limitations.

I have reviewed the above statement, and understand that I am responsible for all costs of dental treatment regardless of insurance coverage. I authorize the release of any information regarding claims, and hereby authorize payment directly to Mt. Hood Dental Clinic of insurance benefits otherwise payable to me.

Patient/Responsible Party: _____

Date: _____