Peter F. Fuerst, D.D.S., P.A

Acknowledgement of Patient Responsibility

1. We are proud to offer expert assistance in maximizing your insurance benefits and filing your claims. We work with many insurance companies and will verify your insurance plan benefits. We will provide as much information and understanding of your policy as possible. However, payment for services is always the responsibility of the policyholder. Please keep in mind, you will be responsible for any fees or amounts not covered under your policy.

2. I agree to pay any portion of the fees not covered by my insurance for **ANY** reason.

3. I understand that Peter F. Fuerst, D.D.S., P.A. can only estimate the approximate percentage my insurance company will pay. I understand any balance remaining on my account after thirty (30) days due to non-payment, lesser payment, or delayed payment by my insurance company is my responsibility.

4. Fees quoted are in effect for ninety (90) days and are subject to change if treatment does not commence within ninety (90) days.

5. I understand that if treatment is started and not completed, and Peter F. Fuerst, D.D.S., P.A. incurs a lab fee, Peter F. Fuerst, D.D.S., P.A. has the right to adjust the balance on my account and charge for temporary services (including doctor time and lab fees). I understand that if I do not complete treatment as recommended the previous adjustments will apply. Any monies rendered will be retained to cover these fees.

6. I understand that Peter F. Fuerst, D.D.S, P.A. will retain and apply any monies I have paid towards the treatment started. Treatment not completed within ninety (90) days of the start date (unless specified) will be charged at the current fee and new co-payments will apply.

7. I agree to cooperate with Peter F. Fuerst, D.D.S., P.A. including keeping appointments, following advice, taking medication as prescribed, properly using appliances and items associated with the treatment.

8. I understand that Peter F. Fuerst, D.S.S., P.A. has a forty-eight (48) hour cancellation policy and will charge an appropriate fee for any and all appointments that are cancelled with less than a forty-eight (48) hour notification. I understand that I will be responsible for payment of that fee at my next scheduled appointment or upon receipt of a billing statement from Peter F. Fuerst, D.D.S., P.A.

9. I understand that Peter F. Fuerst,D.D.S., P.A. will be happy to accommodate my request for the duplication of radiographs that have been taken for the purpose of diagnosis. I acknowledge that Peter F. Fuerst, D.D.S., P.A. will need a minimum of twenty-four (24) hours notice for any duplication request that I make. I also understand that Peter F. Fuerst, D.D.S., P.A. will keep all original radiographs on file and that I will receive a duplicate or copy of my radiographs. I agree to pay Peter F. Fuerst, D.D.S., P.A. a duplication fee of $20 for my request and will sign a records release form as is required by law.

______________________________ Signature

______________________________ Print Name

______________________________ Date