



Patient Financial Responsibility Disclosure

At Paula I Kapec D.D.S., PLLC, we are dedicated to delivering the highest quality dental care. This document serves to delineate the financial responsibilities of patients concerning their dental care and insurance coverage.

Understanding of Fees and Insurance Responsibility

I, the undersigned, acknowledge and accept full responsibility for the payment of all fees associated with the dental services rendered by Paula I Kapec D.D.S., PLLC. I understand that dental insurance is designed to assist with the cost of treatment, but it may not cover the entirety of the expenses incurred. Consequently, I am responsible for any portion of fees not covered by my insurance provider.

I recognize that my dental insurance policy is a contractual agreement between my insurance company and myself, and that Paula I Kapec D.D.S., PLLC is not a party to this contract. I agree to bear full financial responsibility for any charges not paid by my insurance company, irrespective of the reason for non-payment.

Assignment of Benefits

I understand and acknowledge that my dental insurance company may disburse benefit payments directly to me as the plan subscriber. **I commit to presenting any physical insurance check received for services rendered by Paula I Kapec D.D.S., PLLC to the dental office within thirty (30) days from the date of services rendered.** If I do not have physical payment, I agree to contact the office to notify Paula I. Kapec DDS, PLLC of any payment delays within thirty (30) days from the date services are rendered."

Statement and Collection Policy

Monthly statements will be sent to all patients electronically, via email and/or text message, regardless of insurance claim status. Effective 5/31/23, it is my responsibility to confirm and update my email address and phone number on file.

I understand that if a balance remains on my account for more than 60 days, I may be required to render payment before additional services are performed.

In the event my account is sent to collections status, I will be responsible for any additional fees incurred. My signature below confirms that I am fully responsible for the full fee of the treatment performed, irrespective of the outcome from my insurance company's processing of the claim.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

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