

Dr. Jared L. Erickson, DMD
9191 Lee Smith Dr.
Juneau, AK 99801

Patient Name: _____

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of estimated patient portion is due at time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

Cash, Check or Visa/Mastercard, Care Credit®

Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to your insurance coverage. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. We understand insurance guidelines can be hard to decipher and overwhelming at times. With the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes a final determination once treatment is completed and the claim is submitted. We will gladly bill your insurance company for services. **However, since your insurance is a contract between you and your insurance company, you are ultimately responsible for any charges for services provided, in the event your insurance does not pay for services.**

Insurance benefits are payable to the dental office and I agree to release any information necessary for the dental office to process claims on my behalf. Further, I will notify office personnel of any changes in insurance coverage and provide updated cards at the time of my visit.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a monthly finance charge. If my account is turned over to collections, I will be responsible for collection costs incurred by the dental office and a \$30 fee will apply on any returned checks for non-sufficient funds.

Signature: _____ Date: _____