<u>FINANCIAL POLICY OF DRS. DOUG AND CATHY SMITH</u>

This office makes every effort to work with our patients concerning treatment and finances. **Please understand that your bill is your responsibility and your insurance policy is a contract between you and your insurance company.** As a courtesy to you, we will file your insurance; however, we do **require** any portion not expected to be covered by insurance to be paid at time of treatment. Your signature below authorizes the release of any information relating to your insurance claims and authorizes all insurance payments to be made to Dr. Doug Smith or Dr. Cathy Smith.

If you do not have Dental Insurance, payment is expected at time of treatment.

**** I have read and understand the above Financial Policy and agree that I am ultimately responsible for my account regardless of insurance coverage. ****

Signature____

Date____