VALLEYWIDE DENTAL, INC.
Dr. Robert Haze, d.d.s.

Special Note to the Patient

As a courtesy to you we will serve as a third party and bill all claims to your insurance company at no additional charge. We will strive to insure that we have the most updated breakdown of your benefits as possible. We will check eligibility every month, and as requested by you the patient. In the event that your insurance company denies a claim for whatever the cause we will dispute it (Adjudicate Claim) on your behalf.

Unfortunately, any claim that is denied for whatever the reason or cause, you the patient or legal guardian will be responsible for any unpaid portion and must pay the balance immediately.

If you have any concerns regarding this office policy, we are happy to preauthorize any treatment diagnosed. Please be aware that a preauthorization may take up to 3-5 weeks.

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I ______________________________ , acknowledge that Valleywide Dental, Inc. will submit a claim on my behalf to my insurance company. I also acknowledge that I have the right to pay the office in full for the services rendered and submit a claim myself and then get reimbursed by Valleywide Dental, Inc. for the insurance portion only, minus my normal portion share as estimated on my treatment plan.

I have signed the "Assignment of Benefits" and give permission for Valleywide to adjudicate any claim necessary so that they may get paid for services rendered in a timely manner. I understand that any unpaid portion of a submitted claim is my responsibility. I have read and understand the financial policy for Valleywide Dental, Inc. and agree to abide by it.

X: ____ Date: ____________________

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