

**Insurance Guarantee of Payment and Financial Form**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone: (H)** \_\_\_\_\_ **(W)** \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_

**IT IS THE POLICY OF THIS OFFICE TO FILE YOUR INSURANCE AS A COURTESY.**

If payment has not been made by your insurance carrier after your claim has been filed for eight (8) weeks, you will be billed accordingly for these charges. It is then your responsibility to follow-up with your insurance company as to the reason no payment has been made. Insurance companies do not guarantee payment on either written or verbal verification. Insurance coverage is a contract between the patient/employer and the insurance company. The dentist does not enter into this contract, thus cannot be responsible for the lack of payment of any assignment. We will be more than happy to assist you whenever possible.

I hereby agree to guarantee and promise to pay the office of Randall A. Diez, D.M.D all charges incurred in the treatment of the above named patient including those expenses not covered by any insurance policy presently in force. All deductible amounts and non-covered expenses are to be paid in full within ten (10) days of notification.

If any action of law in equity is brought to enforce this agreement, the office of Randall A. Diez, D.M.D. shall be entitled to reasonable attorney fees, costs, and any other costs of collections incurred.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_