Jeffrey L. Sorensen D.D.S.

Thank you for entrusting your family's dental needs to our office. Our office and staff are committed to excellence, offering state-of-the-art technology and providing the best treatment possible; our fees are representative of the fine care you will receive. We do our best to insure that every visit will be a positive one.
Please read through the following and initial after each one. Please ask anyone of us to explain should you have any questions.

Regarding Insurance:

We will accept assignment of benefits from your insurance company provided you furnish us with all the necessary information required in doing so. **Remember, your insurance is a contract between you and the insurance company. We submit to your insurance company as a courtesy to you.** I understand it is my responsibility to know my contracts, limits, exclusions, and annual benefit maximums with my dental insurance, and that I am ultimately responsible for payment regardless of what my insurance pays. If my insurance does not pay within 90 days I will be responsible for payment in full and will obtain reimbursement from my insurance on my own____.

Dr Sorensen's office will estimate my portion to the best of their ability, but my insurance company holds the ultimate say in what I pay out of pocket. My estimated portion will be due at the time services are rendered, unless a prior financial arrangement has been made_____.

I also understand that Dr Sorensen does not base treatment on insurance coverage but on the needs of each individual patient. If I would like the office to send an estimate for treatment prior to having it done, I will request one be sent, and I will follow up with my insurance co. _____.

Payment Options:

1. **Payment in full at time of visit.** (cash, personal check, credit card)_____.

2. **Financing is available through:** *Care Credit* a Health Care credit card with no annual fees and offers interest free financing for terms based on the amounts borrowed____.

3. **5% Courtesy Adjustment** for patient portion paid prior to your scheduled appointment_____.

Minor Patients:

The adult accompanying the minor patient is responsible for payment at each visit. The same policy applies for separated or divorced parents_____.

Missed Appointments

Dr Sorensen considers every patient equally as important as the next. Therefore, if I cannot make my appointment I will give at least 24 hours notice so the office can allow another patient to take my place in the schedule. I understand that a fee will be charged if I do not give proper notice_____.

Courtesy Call

Our office uses a courtesy automated phone call reminder system. I understand that this system will call me prior to my appointment to remind me, but I know it is my responsibility to keep track of any appointment I have_____.

I have read and initialed all of the above options and have a clear understanding of all.

_____ _____
Signature Date

24418 75th St
Paddock Lake, WI 53168

262-843-2004