CHESAPEAKE
Dental Arts

www.ChesDentalArts.com

1509 Ritchie Hwy · Arnold, MD 21012 · (410) 757-6200

Patient Name _____Date _____

Please initial the following:

I understand all treatment plans are only an estimate and may differ from actual payments. I am responsible for the difference. _____

I understand that no financial arrangements will be made after work has been initiated. _____

Many carriers do not offer coverage for Composite (White Fillings). Any balance left after insurance pays will be my responsibility _____

I understand that if any work I have done is denied by my insurance company I am responsible for the balance _____

I understand that 50% of my copayment is due on the start of my major restorative work and the remainder is due on the insertion. Any balance left after insurance pays will be my responsibility _____

When we do dentures we do not take a write off from the insurance company. Patient is responsible for any balance after insurance pays. _____

No appointments will be scheduled for any individual or family member with a balance.
All work must be paid in full on the day of insertion or delivery. ____