128 Lakewood Center Mall
Lakewood, CA 90712
(562) 531-7788

NOTICE TO INSURANCE PATIENTS

I understand that I am responsible for my balance with **iSmile Dental Care**, including under the following circumstances:

A: The treatment goes over my insurance company's yearly maximum benefit.

B. My insurance company denies treatment.

C. I am not eligible for insurance.

D. The insurance benefits are less than what was indicated on **iSmile Dental Care's** Estimator.

E. I prevent or delay payment by not complying with requests for insurance forms and signatures.

F. I do not complete my treatment and it results in non-payment by my insurance company.

G. Lab costs are incurred due to my failure to appear at my appointments.

H. **I RECEIVE MY INSURANCE CHECK AND DO NOT SEND IT TO iSmile Dental Care.**

I have read and understand that I am financially responsible for all charges not paid by my insurance.

Signature: _____

Date: _____