ORAL SURGERY SPECIALISTS
OF PUEBLO

Financial and Insurance Disclaimer
(Please read carefully)

Payment is required to be paid in full at time of service unless other arrangements are made in advance.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental insurance. When we verify your insurance benefits, it is not a guarantee of coverage or payment by the insurance company and benefits may vary according to your individual plan when the actual claim is submitted.

Please be aware that your dental policy is a contract between you, your employer, and your insurance company; and not with Oral Surgery Specialists of Pueblo. Your insurance policy is your responsibility. In addition, you should be aware of what your insurance policy covers, when it starts, when it ends, etc. You also understand that if your insurance company does not pay within 120 days of your date of service then you will become responsible to pay at this time.

Any treatment estimate that our office presents to you is an estimate of what your insurance may cover and is not a guarantee of insurance coverage or payment. If you need exact payment of insurance benefits then we require an in person consultation first before sending a "pre-authorization." If you would like this done, you must notify our office staff before any treatment is started. (This could take approximately 6-8 weeks). _____ (Initial)

Estimates are subject to modification depending on following including but not limited to: changes to procedures due to unforeseen dental conditions during treatment, other dental treatment provided at other provider offices, termination of policy, change of policy, waiting periods, maximums, deductibles, frequency or limitations, etc… Your policy may require you to pay a deductible, co-pay, or require that you pay for the entire service or procedure depending on the policy language.

By signing below you acknowledge the terms above and understand that you are responsible for all costs of dental treatment regardless of insurance coverage.

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Patient Name (Please Print)

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Patient / Parent / Legal Guardian (Signature) Date