TriMark Dental Clinic, LLP

Dr. Patricia Lyons and Dr. Tonya Wason

2130 Kennedy Rd, Janesville WI 53545

Thank you for choosing TriMark Dental as your dental care provider. We are committed to providing you with the highest quality dental care. We ask that you read and sign this form to acknowledge your understanding of your patient financial responsibilities.

Patient Financial Responsibilities

- The Financially Responsible Party as identified on the Patient Information form and who signs on this form is ultimately responsible for the payment of treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Co-pays are due at the time of service. Payment plans are available and can be set up by putting a Credit/Debit card on file along with a designated date for payment allowed.
- Co-insurance, deductibles, and non-covered items are due within 30 days from receipt of billing.
- In the event that a dental insurance plan determines a service to be “not payable”, the Financially Responsible Party will be responsible for any unpaid balances for treatment. The Financially Responsible Party agrees to pay the costs of all services provided. If there is a written agreement between the insurance company and TriMark, we will honor that agreement in accordance to the contract.
- Patients may incur, and are responsible for payment of additional charges, if applicable, such as:
    - Charges for returned or cancelled checks or other bank fees associated with a payment.
    - Charges for missed appointments without the 24 hours’ notice

By signing below, I acknowledge I have read, understand, and agree to my financial responsibility as discussed on this form. I hereby authorize assignment of financial benefits directly to TriMark Dental and any associated dental care entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Printed Patient Name: ___________________________________ **Patient DOB:**______________________

Signature of Financially Responsible Party: ____

Printed Name of Financially Responsible Party **(IF NOT SELF)** ____

Relationship to Patient: _________________________________ **Todays Date:**__________________________