Central Wisconsin Endodontics, LLC

Thomas C. Westrick, DDS

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Insurance/Financial Authorization and Agreement

I understand that as a recipient of care provided at Central Wisconsin Endodontics, LLC I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).

The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Central Wisconsin Endodontics, LLC, Thomas C. Westrick, DDS all benefits. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility.

Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances. Should my insurance cover all services, the money paid at the time of service will be refunded upon final insurance payment.

***I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING**:*

1. Providing Central Wisconsin Endodontics, LLC, Thomas C. Westrick, DDS with complete and accurate billing information, including, but not limited to, a current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized. ***(NOTE: our computer software is capable of submitting claims to only two(2) insurances. It is the patient's responsibility to submit claims to any additional insurances).***

2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit.

3. WE WILL ALLOW 90 DAYS FOR YOUR INSURANCE COMPANY TO MAKE A PAYMENT. AFTER THAT TIME ALL INQUIRIES OR FOLLOW UP IN PAYMENTS DUE BECOME YOUR RESPONSIBILTY.

Patient/Guardian Signature _____ Date_____

Acknowledgement of Receipt

I acknowledge that I have been offered a copy of Central Wisconsin Endodontics, LLC- Dr. Thomas C. Westrick's NOTICE OF PRIVACY PRACTICES, and that it is my choice to take one or not.

Initials_____ Date_____