Gentle Family Dentistry

Gordon D. Keyes, D.D.S., Inc.

Patient Responsibility Notice Waiver Form

Patient Name: _____

Dr. Gordon Keyes provides many different types of dental services including exams, emergency treatment, fillings, crown, extractions, root canals, periodontal treatment and all forms of general dentistry. Although most insurance companies cover a percentage of most services, there are some insurance companies that do not cover certain types of procedures.

Our staff makes every effort to assist you in understanding your dental health benefits. However, it is impossible for us to know all the many different employer group benefits from one employer to the next. Therefore, we are providing this Notice to inform you of the following responsibilities by the patient and Dr. Gordon Keyes.

Dr. Keyes' Responsibilities:

Dr. Keyes is not responsible for knowing what services are covered by the patient's insurance plan and is not responsible for informing the patient whether a particular service is covered. Dr. Keyes is not responsible for knowing if he is an IN-NETWORK PROVIDER.

Dr. Keyes will assist the patient in obtaining the payment from his/her insurance company by submitting the necessary insurance claims.

Patient's Responsibilities:

Patients must provide proof of insurance prior to being seen in the office. It is the patient's responsibility to check their benefits and eligibility prior to being seen. It is the patient's responsibility to verify that Dr. Gordon Keyes' office is an IN-NETWORK PROVIDER. It is the patient's responsibility to know and understand his/her own dental insurance benefit coverage and limits. The patient is ultimately responsible for payment for all services rendered by Dr. Keyes at the time of treatment, and the patient must pay for any services not covered by the patient's insurance company. If there is any dispute with the patient's insurance company regarding coverage, eligibility, unpaid balance it is the patient's responsibility to resolve the issue. ***Patient's Initials*** _____

If the patient is covered through someone else's plan (parent, spouse, etc) they have verified that they are enrolled and have reviewed their benefits. If the patient has family members established in the office, they have verified that they are enrolled and covered through the plan. ***Patient's Initials***_____

By signing below, I hereby acknowledge and understand my responsibilities as a patient of Dr. Keyes and accept that Dr. Keyes is not responsible for knowing my dental insurance benefits for services provided. ***Patient's Initials***_____

_____ _____

Signature of Responsible Party Date