



TriState Family Dental Centers

A Professional Corporation

Established in 1971 by

John B. Schymik, D.D.S. & Stanley R. Nevill, D.D.S.

Mark J. Schymik, D.D.S.
Noble H. Sevier II, D.D.S.

Andrea S. Conrad, D.M.D.
Brandy M. Greco, D.D.S.

Third Party Liability Form

Patient's Name: _____

Date: _____

I, (Name of Third Party) _____, the undersigned, do promise to pay the expenses for care rendered by TriState Family Dental Centers for the above named patient until I notify in writing of any change.

Third Party Information:

Name: _____
SS #: _____
Date of birth: _____
Address: _____
Phone #: _____
Employer: _____
Employer address: _____

Please fill out the following if the patient listed above is covered by the Third Party's dental insurance plan.

Dental Insurance Name: _____
ID #: _____
Group #: _____
Insurance Address: _____
Insurance Phone #: _____
Relation to Patient: _____

FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my signature on all insurance claim forms at the offices of TriState Family Dental Centers for payment directly to them for services rendered. I authorize TriState Family Dental Centers to make and send copies of dental records that may be needed to file my insurance claims. I understand that I am responsible for charges incurred regardless of whether or not my insurance pays. I understand that office policy requires payment in full or the estimated portion not covered by insurance at the time of service unless other arrangements have been made with the credit manager. Past due balances are subject to a 1.5% per month (18% APR) service charge. I understand and agree that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33.33% will be added to my account. I further agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.

(Signature)

(Date)