INSURANCE POLICY

As a courtesy to her patients, Dr. Barrineau will file claims to your insurance company. However **Dr. Barrineau is not a provider for any insurance plan.**

I_____understand and agree that dental insurance and accidental policies are an arrangement between an insurance carrier and myself. All fees incurred for any treatment received are my responsibility in it's entirety. However I understand that Dr. Barrineau's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid, be paid directly to Dr. Nicole Barrineau, and will be credited to my account on receipt. Although we will make every effort to closely calculate your benefits we cannot be responsible for your insurance company's decision to reimburse at levels less than originally estimated. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I authorize payment of benefits directly to Dr. Barrineau. I agree to be responsible for any portion not paid by my dental insurance carrier within 60 days on my behalf, or on the behalf of my dependents.

I authorize the release of any information to process insurance claims or to referring specialists including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and or other health practitioners.

I certify that the dental/medical history is true and accurate to the best of my knowledge and that I have read and agree to the credit policy as listed above.

_____Date_____

SIGNATURE OF PATIENT OR PARENT IF MINOR