J. Brewster Bede, DDS
David W. Branch, DDS
Casey E. Carmody, DDS
720 Olive Way #800
Seattle, WA 98101

NOTICE TO INSURANCE PATIENTS

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCUR:

- The treatment goes over my yearly maximum
- Any treatment that is denied by my insurance company
- I am not eligible for insurance
- I do not complete my treatment and it results in non-payment by the insurance company
- I prevent or delay payment by not complying with requests for insurance forms or signatures.
- I received my insurance check and do not send it to the office

I have read and understand my obligation in acceptance with the dental insurance as payment.

Signed: _____ Date: _____

(Patient or responsible party)

NOTICE TO NON-INSURED PATIENTS

- I must make financial arrangements for payment of services prior to the commencement of treatment for dependents and myself.
- Any outstanding balance for prior services must be paid before any other dental work is started.

Signed: _____ Date: _____

(Patient or responsible party)

Please print, sign, and bring this form to your first appointment.