RESPONSIBILITY FOR PAYMENT

Please read carefully, complete and sign below

PATIENT NAME *(Please Print)* _____ **CHART #** _____

GUARANTOR INFORMATION: PATIENT/PARENT/GUARDIAN **RESPONSIBLE FOR PAYMENT**

GUARANTOR NAME(S): _____ _____
RELATIONSHIP TO PATIENT: _____
ADDRESS: _____
PHONE#: _____ WORK#: _____ CELL#: _____

IS THE PATIENT COVERED BY DENTAL INSURANCE: ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION (Please do not use abbreviations)

Insurance Co. Name	_____	Insurance Co. Name	_____
Policy ID Number	_____	Policy ID Number	_____
Group Number	_____	Group Number	_____
Name of Employer	_____	Name of Employer	_____
Policy Holder Name	_____	Policy Holder Name	_____
Policy Holder DOB	_____	Policy Holder DOB	_____

Indicate any other types of dental/orthodontic insurance:

☐ Healthy Smiles Ontario Account#_____ Expiration Date_____

☐ ODSP (18 years & older) Account#_____ ☐ Children's Aid Society ☐ Non-Insured Health Benefits

☐ Interim Federal Health Program ☐ Cleft Lip & Palate/Craniofacial Dental Program ☐ Other: _____

FINANCIAL & DENTAL INSURANCE POLICIES I understand that:

- **OHIP does not cover Dental Services.**
- Full payment is due at the time of service.
- All charges are ultimately the responsibility of the patient/guarantor (regardless of insurance).
- Any fees quoted for this office's treatment plans will be honoured for 9 months (excludes insurance pre-estimates).
- If my account becomes delinquent I may be referred to a third party for collection.
- Future dental services may be limited and/or denied for all persons under my account until my account is current.
- In case of payment needing to be made by phone or email, we require authorization to charge the credit card the agreed amount. (Please initial_____)

I authorize Holland Bloorview dental services to submit on my behalf manually/electronically to my dental insurance benefits claims and estimates. I also understand that Holland Bloorview dental services is a non-assignment practice, meaning payment is due day of service. I will be reimbursed (according to my policy) from my dental insurance benefits. I certify that I have read and do hereby agree to the above stated financial policies of this office.

_____ _____ _____

Patient/Parent/Guarantor Signature *Patient/Parent/Guarantor Signature* *Date*

IMPORTANT! Your signature confirms the accuracy of the information you provided and an understanding that dental fees will apply to each visit. *Claims for services performed for clients who have dental benefits under a private dental plan contract or insurance policy*, **must be submitted through the private plan first, before any claims can be made to any government assisted program.** (Please initial_____)