HANDSMAN & HADDAD PERIODONTICS P.C.

ADVANCE BENEFICIARY NOTICE

All services provided to you as a patient of HANDSMAN & HADDAD PERIODONTICS P.C. are payable at time of service and are the sole responsibility of you "the patient" and/or guarantor of "your children".

As a courtesy for patients with private paid insurance, the PROVIDER will file with your insurance company. Please be advised that dental care plan benefits vary greatly by employer, by insurer, and by plan type. Therefore, certain services may be denied by your plan as "non-covered", but you are still financially responsible. You are also responsible for payment of all plan deductibles, co-payments, co-insurance and any other non-covered services. Plan co-pay will be collected at "time-of-service" and credited to your account against the charges for the services rendered. After your insurance company has either paid or denied payment on your charges, an invoice for the balance due less the co-pay, if applicable, will be sent to you.

Therefore, I understand and agree with the statement above that the liability for the payment for services provided to me and my family is my sole responsibility. Should my insurance plan not reimburse the PROVIDER in full, I will personally and fully be responsible for any and all remaining payment. I further understand that this is the official position of the provider on this topic.

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Patient Name (Printed) Date of Birth

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Patient/Responsible Party Signature Date of Service