Carlos J. Privette
970 Northwoods Drive.
Cary, NC 27513

Patient Name:______________________________
(Please Print)
Dental Ins. Co.:______________________________
(If Applicable)

STATEMENT OF FINANCIAL RESPONSIBILITY

I, the undersigned, understand that I am financially responsible and consent to be guarantor of payment of all charges incurred. As a courtesy this office will file dental insurance claims and cannot be responsible for collecting or negotiating disputed insurance payments for the insured. I understand that if release of dental insurance benefits is delayed for more than 45 days I am financially responsible, and should expect to pay the total balance on the account for the date of service in question. I further understand that insurance reimbursment is a contract between my insurance company and myself. I understand that my insurance company's usual, customary and reasonable allowance (UCR) does not reflect the provider's fees for service. Insurance allowances are determined without consultation with the provider.

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Responsible Party Name (please print)

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Responsible Party Signature