David R. Stasiak DDS
Vincent J. Fiorella DDS
Thomas M. Scibor DDS

Hillview Family Dental P.C.

6347 Transit Road
Depew, N.Y. 14043
Telephone (716) 681-5468
Fax (716) 706-1106

Statement of Financial Responsibility

Patient Name:_____ Date:_____

Hillview Dental appreciates the confidence you have shown in choosing us to provide for your dental needs. The services provided imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will file your claim with your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill as our service contract is between us, as the service provider, and you, the patient.

You are responsible for payment of any co-payment and deductible at the time of service and on receipt of a bill for any other coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that periodically change and that may affect your coverage. You are responsible for any amount not covered by your insurer.

I have read the above policy regarding my financial responsibility to Hillview Dental for providing dental services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Hillview Dental. I agree to pay Hillview Dental the full and entire amount of all bills incurred by me or the above named patient.

I also understand that the cancellation policy at Hillview Dental is as follows: 24 hrs notice of cancellation is required. Failure to cancel prior to 24 hrs may result in a missed appointment fee of $25.00.

Signature: _____ (relationship to patient: self-guardian-other) _____ Date: _____