



*McCart Family  
Dentistry*

*"serving the community with excellence"*

## **Insurance Agreement**

**I, ( patient/guardian name ) \_\_\_\_\_, fully understand that it is a benefit provided to me when McCart Family Dentistry files my insurance for any service rendered or treatment performed. It is my responsibility as the insured to inform the front office staff of any changes to my insurance policy. I fully understand that McCart Family Dentistry will estimate insurance payments based on information provided by me and my insurance company. I also understand that insurance companies may disclose inaccurate information when verifying my benefits. If the insurance company does not pay for some or all services, I am fully responsible for any unpaid / denied charges. A written insurance policy is provided to me, not McCart Family Dentistry; therefore, it is also my responsibility to verify and understand my coverage.**

**Thank You,**

**McCart Family Dentistry**

**Signature: ( patient / guardian ) \_\_\_\_\_ Date: \_\_\_\_\_**