**E.O.B (Estimate of Benefits) Acknowledgement**

**I hereby understand, acknowledge, and realize that any pre-determinations for dental treatment that is sent back by insurance companies for pre-authorization are considered, Estimates of Benefits. In our experience, insurance companies return pre-authorizations for dental work with no guarantees of their coverage nor to what extent they may or may not cover such dental procedures. By signing this document, you agree to be financially responsible for any and all fees not covered by your insurance carrier within thirty (30) days of submission of electronic claims. We will do our utmost to ensure that the carrier has all of the information needed to process the claim. If for some reason, the carrier decided to not process the claim, to leave it on their desk, or for any other unknown reason, we are not responsible. We are asking all of our patients to contact their insurance carrier three (3) days after their treatment to ensure they have no questions about the information received. Again, we will do our utmost in your service to ensure that all information required is in their hands expeditiously.**

**We are always trying to understand in your benefit how insurance companies work. It is a mystery in many cases, and unfortunately, we are just as mystified as you.**

**Thank you for your understanding and as always, choosing us for your dental care needs.**

**Patient acknowledgement with no further questions of this document:**

**Please Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**