Jeff H. Cumberland, D.M.D.
Lynsey Cumberland, D.M.D.

AUTHORIZATION AND PAYMENT AGREEMENT

As a courtesy to you, the patient, we will file your dental insurance for procedures performed. I understand that I am responsible directly to Dr. Cumberland for payment of this account regardless of the status of dental insurance claim reimbursement. I also authorize payment of dental benefits otherwise payable to me, directly to Cumberland Family Dentistry, PLLC.

I authorize Drs. Jeff and Lynsey Cumberland to release information acquired in the course of treatment, including information necessary for the processing of insurance claims and inquiries to the insurance company, to any dentist, physician, hospital, and/or any medical care facility.

I understand that insurance payments are typically made within 30 to 60 days from the date of service provided. **If your insurance company has not made payment to our office within 60 days, we kindly ask that you pay the balance on your account at that time.** From this point forward, you will then be responsible for seeking reimbursement from your insurance company for that particular claim.

Our office does not guarantee that your insurance company will pay for the treatment recommended or performed by Dr. Cumberland and/or staff. As a courtesy, our office will verify coverage benefits and file insurance claims on your behalf. We can provide you with an estimate of how your insurance company will pay for particular procedures, but we are not provided their reasonable and customary fee that the percentage of reimbursement is based upon. **However, if your claim is denied, you will be held responsible for paying the amount in full at that time. Our dental treatment is not based upon your insurance coverage, but upon providing you with comprehensive dental care that may require some out-of-pocket expenses.**

I authorize Drs. Jeff and Lynsey Cumberland to request radiographs (x-rays) and/or notes from any dentist, physician, hospital or medical care facility. I authorize photocopies of this to be valid as the original.

I agree to be responsible for the payment of this account. I agree that this authorization is good for my lifetime. **I understand that payment is expected when services are rendered unless other financial arrangements are made in advance. A monthly service charge of 1.5% per month (18% per year) will be added on all accounts not paid within 30 days.**

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Signature of Patient or Insured Date