Insurance Disclaimer

We will gladly process your insurance claim, estimate your deductible, and the portion not covered by insurance. The estimated amount not covered by your insurance is due at the time of treatment. Please note that our office does **NOT** participate as a "provider" with any insurance company, therefore, we are "**OUT OF NETWORK**".
Your initials here ________

Assignment and Release of Benefits

I agree to assign benefits directly to Mark B. Gilbert D.M.D., PA. I understand that I am responsible for all charges, whether or not paid by insurance. I authorize the release of information to my insurance carrier and the use of this signature on all my insurance submissions whether manual or electronic.

Broken Appointment Policy

Important: If you are unable to keep your scheduled appointment with us, we do require that you provide us with 24 hours notice prior to your appointment. If we do not hear from you, there will be a broken appointment fee of $50.00 charged to your account.

Patient Consent To Receive Mail and Telephone Calls

Where may we reach you regarding the following:

Appointment information - Home___ Work___ Cell__
Billing information - Home___ Work___ Cell__
Dental/Medical information - Home___ Work___ Cell__

We may share appointment information with the following person(s)_______________
We may share billing information with the following person(s)____________________
We may share dental/medical information with: _____________________________

NOTE: I understand that I have the right to review the Notice of Privacy Practices prior to signing this document.

I acknowledge that I have read and understand ALL of the above.

______________________ ______________________________
Date Signature