McGee Family Dentistry

OUT OF NETWORK INSURANCE ACKNOWLEDGEMENT

I, _____, have been advised that the providers at **McGee Family Dentistry** are not an "in-network provider" for my insurance plan _____; therefore, services provided to me, and billed by **McGee Family Dentistry** and the billing service, will be considered "**out-of-network**" services.

Under this acknowledgement, I understand that my insurance carrier may pay for services rendered at a lower rate compared to those considered as "in-network." I agree to pay the *anticipated* total charges on the dates of service. I will assume the responsibility to respond to any financial correspondence furnished by **McGee Family Dentistry** and the billing service, and I also agree to pay any outstanding/remaining difference(s), if my initial out-of-pocket payment is not sufficient to satisfy my account once my insurance company has been billed.

_____ _____

Patient Name (printed) Patient Signature

_____ _____

Guardian Signature Relationship to Patient

_____

Today's Date

**Any overpayments on accounts will be appropriately refunded once the account has been adjusted and completely satisfied*

Staff Initials: _____