Laconi Dental

11 Skyview Drive
Chesterfield, IN 46017
765-378-0271

I understand that all charges are my responsibility to pay, regardless of insurance coverage. I shall be responsible for all fees incurred for service provided to me and my dependants. I further acknowledge I will be responsible for collection fees, attorney fees, and court costs incurred in any attempt by provider to collect amounts I may owe. I authorize payment of dental benefits to the above name provider. I authorize release of medical information to my insurance carrier for claim processing purposes and to any collection agency or attorney hired by provider.

____ ____________________
Signature Date

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Print Name