Acknowledgement of Financial Responsibility

Please initial each individual statement, signifying you understand each statement, and sign where indicated.

_______I understand that Nebraska Myofunctional Specialties, LLC and Patricia Brinkman-Falter are fee-for-service providers and not preferred providers or in-network therapists for any dental or medical insurance companies.

_______I understand that although they are not preferred providers or in-network therapists for any dental or medical insurance companies, Nebraska Myofunctional Specialties, LLC will provide superbills and a GAP exception letter so I may submit to my insurance to realize any out-of-network medical benefits from my insurance policy.

_______ I authorize the release of medical or other information necessary should the insurance company contact Nebraska Myofunctional Specialties, LLC. I understand that approval of services by my insurance company does not mean they will be reimbursed.

_______I understand that the Nebraska Myofunctional Specialties, LLC does not accept assignment from the insurance companies and if the insurance payment is assigned to Nebraska Myofunctional Specialties, LLC it will be reimbursed to me or credited to my account.

_______ I understand that that Nebraska Myofunctional Specialties, LLC does not accept insurance payments as payment in full. I agree that I will be responsible for all services not covered or denied by my insurance company, as well as any fee charged for missing an appointment or failing to *cancel an appointment four or more hours* in advance of that appointment.

_______I understand that if I arrive late (>15 minutes) that I will be offered the next available appointment. In these cases, a no-show charge for the lost appointment will apply. While we will do all that is possible to accommodate requests, the first-available appointment *may or may not be* on the day the appointment was missed.

_______I understand that the fee for my consultation appointment is due the day of the consultation appointment.

_______I understand that any subsequent treatment I agree to with Patricia Brinkman-Falter of Nebraska Myofunctional Specialties, LLC will require a signed treatment plan and that Nebraska Myofunctional Specialties, LLC offers a limited variety of payment plans for treatment.

______ I understand that there will be a 1% compounded interest charge each month on any unpaid balances.

By my initials above and signature below, I acknowledge understanding of my financial responsibility for seeking treatment at Nebraska Myofunctional Specialties, LLC.

____ ________________________
Signature Date

____
Printed name of Patient