



Dental Art Care P.C
481 83rd Street, Brooklyn N.Y, 11209
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Fax: (718)748-9400

Patient Name: _____
Last **First** **Initial**

I, _____, understand that if my insurance carrier fails to make payments for any work that has been performed, I will be held responsible for payment, and if I fail to submit my payments in the time discussed, my case can be passed on to collection.

Patient's signature: _____ **Date:** _____

Doctor's signature: _____ **Date:** _____