THOMAS R. HIRSCH, D.D.S.
A PROFESSIONAL CORPORATION
23440 CIVIC CENTER WAY, SUITE 206 • MALIBU, CA 90265 • (310) 456-3363 • FAX (310) 456-7188

INSURANCE CLAIM AGREEMENT FORM

I, _____UNDERSTAND THAT THE OFFICE OF DR. THOMAS HIRSCH DDS. IS A FEE FOR SERVICE OFFICE AND THAT PAYMENT OF SERVICES ARE DUE AT THE DATE OF MY APPOINTMENT.

I UNDERSTAND THAT ANY INSURANCE CLAIMS ARE SENT AS A COURTESY AND THAT IT IS MY RESPONSIBILITY TO FOLLOW UO WITH MY INSURANCE COMPANY FOR ANY REIMBURSEMENT IS NOT RECEIVED TO ME IN 3 MONTHS.

I ALSO UNDERSTAND THAT, DR. THOMAS HIRSCH'S OFFICE, IS NOT RESPONSIBLE FOR FOLLOWING UP WITH MY CLAIMS AND OR REIMBURSEMENTS BEING PAID DIRECTLY TO ME.

PATIENT SIGNATURE_____ DATE_____