Core Dental Health
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Patient Responsibility Form

I understand that as the parent/legal guardian, I will be responsible for payment in full for any service(s) rendered to my child/children by Dr. Jesse Ellsworth and his staff. I may submit insurance information: however, if the insurance carrier(s) does not pay the entire balance, or denies or rejects my claim for any reason, I understand I will be responsible for paying in full any remaining balance(s) on my account(s).

Signed_____ Date_____ Relationship_____