

**GEORGIA SMILES**  
780 SCENIC HWY  
LAWRENCEVILLE, GA 30046  
678-215-1300

I \_\_\_\_\_, confirm that I will continue the responsibility for \_\_\_\_\_ all dental payments and account balances.

**It is your responsibility to contact your insurance company to confirm that our provider is participating with your plan. It is also your responsibility to understand your insurance benefits and requirements. If your insurance company for any reason does not pay for the services rendered, you are responsible for any unpaid balance on the account.**

**SIGNATURE: \_\_\_\_\_**  
**DATE: \_\_\_\_\_**