



DAG ZAPATERO, D.D.S., M.A.G.D.

3020 Shore Drive, Virginia Beach, VA 23451

**REGARDING PATIENT INSURANCE**

As a courtesy to our patients, we electronically file your dental claims for any treatment you have received. This claim shows a description of services provided, the date, and charges.

Although, we provide this insurance claim filing service to you with your insurance carrier, it is **ultimately your responsibility for payment**. We will follow-up unpaid claims filed, but we do not accept any liability for lack of coverage, amount of benefit provided, or slow payment by a carrier. As the policyholder it is your right to question the insurance carrier about delays in payment and/or the amounts paid. We happily offer whatever assistance we can reasonably give. Your satisfaction is important to us. If you have any questions please ask Jennifer who will be more than happy to assist you.

**We are only participating provider with Delta Dental Premiere of Virginia.**

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**AGREEMENT FOR PAYMENT**

If this account is referred to an attorney for collection then the undersign person(s) promise and agree to pay all collection costs including attorney fees of 33 1/3% of the principal amount due and owing when turned over for collection and do further agree to pay interest of 1 1/2% per month (18% per Annum) on the unpaid balance from the date the services were last rendered. In the event this matter is turned over for collections, I hereby expressly give permission for my current employer(s) to provide verification of my said employment to this office, or attorney, Tiffany & Tiffany, P.L.L.C.

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**DENTAL INSURANCE REGISTRATION**

**AUTHORIZATION FOR SIGNATURE ON FILE / ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_, hereby authorize the office of Dag Zapatero, D.D.S., to attach my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Dag Zapatero, D.D.S. This Signature on File will be valid from this date and shall expire at the lifetime of the patient in the practice. A photocopy of this document may act as an original. You shall also be responsible for notifying us of any changes in your employment or insurance carrier, and that you consent to all policies described on this page.

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Signature of Insured

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Witnessed by

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Today's date