**DONALD SAMPSON, D.D.S.**
6939 Littlerock Rd SW Suite B
Tumwater, WA 98512
www.tumwaterfamilydentistry.com
360-352-0401

I, _____ hereby certify that I am eligible for dental coverage through

_____ as of _____

Month/Day/Year

I understand that if the above is not true or if my insurance denies payment for any said reason under the terms of my Dental Subscriber Agreement, I am liable for all charges and for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered, within 30 days from receiving a bill from Dr. Donald G. Sampson.

***I understand that if my insurance company changes and I fail to notify Dr. Donald Sampson, I am responsible in full for all services rendered.***

| Signature of Member/Patient | Date Signed | Witness |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |