DENTAL INSURANCE/FINANCIAL RESPONSIBILITY

As a courtesy to our patients we are happy to help you file the necessary dental insurance forms so that you can receive the fullest possible benefits allowed by your insurance company.

However, we make no guarantee of dental coverage or benefits. Your insurance policy is an agreement between you and your insurance company.

Dental offices are given a limited amount of information regarding benefits, co-pays and coverage. Any questions should be addressed with your insurance company and/or human resource officer.

WE WILL:

1. File your insurance at no charge if our dental office is provided a current insurance card and driver license.
2. Verify your insurance by calling the company and explain your coverage to you based on the information received from your insurance company.
3. We will stay in contact with your insurance company in an attempt to have the claim processed in less than 45 days.

PATIENT RESPONSIBILITY:

1. Co-pay and deductibles are due at the time the service is provided.
2. Any charges NOT reimbursed by your insurance company must be paid within 45 days of treatment.
3. Inform our office staff 48 hours prior to your scheduled visit of new dental insurance. We cannot file your insurance unless we have a valid dental card and photo identification on file. To verify coverage we MUST be told ahead of time.

I, hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

If I do not pay the entire new balance within 25 days of the monthly billing date a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last months balance. In the case of a default payment, I promise to pay any legal interest on the balance due, together with any collection costs, and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

I agree and understand the above:

Signed_____Date_____