Dental Insurance Information

Please read the following carefully!

As a courtesy to you, our patient, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. However, we cannot know exactly what or how much your coverage will be. We can estimate what we think insurance will pay, but please understand that with so many different insurance companies and several plans within a single company, it is difficult to be certain. We will, if you would like, and are willing to wait, submit a pretreatment estimate to the insurance company to help answer any questions you may have about assignment of benefits for a particular procedure. After the insurance company disperses payment, if there is a balance, you will be billed for the remaining portion. If there is a credit, then a check will be mailed.

Please be aware: You, the patient, are responsible for your entire account balance. Your insurance is a third party pay or with whom we have no contract with. Insurance is a relationship between you and your carrier. If, for some reason, your insurance company does not pay on your claim, you will be expected to pay in full within 30 days of the date of treatment. If your insurance company becomes unduly difficult to deal with, we will require that you pay the balance and proceed to collect on your claim directly.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care for myself and children of record in this office. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my (or my child 's) health care, advice and treatment to or from any other health care provider.

I hereby authorize payment of insurance benefits directly to the dentist, or dental group, otherwise payable to me.

I understand that my dental care insurance canier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous statements to the contrary and agree to be responsible for payment fo services not paid, in whole or in part by my dental care payor.

Patient or Guardian's Signature _____Date _____