TO ALL PATIENTS

I understand that professional services are rendered and charged to the patient and NOT to the insurance company. Our office cannot accept responsibility for negotiating a settlement on a disputed claim and/or collecting on a past due account.

INSURANCE INFORMATION

I
1. Primary Insurance Co. Name: _____
2. Billing Address: _____
3. Employee Name: _____
4. Employee S.S. ID #: _____ Policy #: _____
5. Employer: _____ Patient Relationship to Insured: _____

II
6. Secondary Insurance Co. Name: _____
7. Billing Address: _____
8. Employee Name: _____
9. Employee S.S. ID #: _____ Policy #: _____
10. Employer: _____

III College Student Name: _____

Units _____ School: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire expense, I will be responsible for payment of the difference; and if the nature of the treatment be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

Signed _____ Date _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with your practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment Cash, Credit Cards, Checks. **Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $50.00 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our office.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____*(initial)*

I have read the above and agree to the financial and scheduling terms. _____*(initial)*

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) _____*(initial)*

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____*(initial)*

Signature _____ Date _____