I HAVE DENTAL INSURANCE

Among the many changes that are occurring in the healthcare industry today, the proliferation of HMO and PPO plans is one of the most challenging. Our decision to participate with some of the plans is based on a desire to serve the needs of our patients and is subject to change as the industry changes and our patients needs.

We are happy to participate with these plans for our patients. Likewise we ask our patients to understand that our role is to be your dentist and provide you with competent and caring services. That has always been our commitment and will continue to be so regardless of the changing environment.

As a convenience to our patients with dental insurance, we will submit your claims to your carrier. We do ask that you provide us with a signed and completed claim form and or accurate information and to keep us current of any changes in the policy or the carrier itself.

Please understand that your insurance is a contract between you and your insurance company, not the insurance company and the office. We will try to maximize your benefits to meet your dental needs. No insurance company covers all dental costs. It is your responsibility to pay any deductible, co-insurance and any balance not paid for by your insurance company. All managed care co-pays are paid at the time of visit.

A. I will pay any deductible and estimated out-of-pocket or co-pay on the date of service.

B. When a lab fee is involved I agree to pay 1/3 per unit on the impression date as a lab deposit and the balance to be paid in full upon delivery.

C. I agree to be responsible for all charges for dental services and materials not paid for by my Dental benefit plan. I request payment directly to the office. This authorization is valid until I notify the office otherwise.

_____
(Patient / Parent)

OR

In exchange for prompt payment courtesies, I will pay in full at the time of the visit and have the insurance company reimburse me.

_____
(Patient / Parent)

ALL PATIENTS

Be advised of **1.5% monthly late fee** on personal balances over 30 days and any collection or attorney fees are the debtor's responsibility. Returned or canceled checks have a $25.00 bank fee.

Be advised there is a $30.00 fee for appointments broken without 24 business hours notice.

SIGNED _____ _____
(Patient) (Responsible Party)

DATE _____

Who can we talk to about your personal medical information?

Who can we not talk to about your personal medical information?

Any phone # or email address we can not leave sensitive information on?

For minors, who is the legal guardian?