

INSURANCE INFORMATION

Primary Insurance

Subscriber name _____

Relation to pt _____

Address _____

SS # ____ - ____ - ____

Date of Birth ____/____/____

Employer _____

Dental Insurance Co. _____

Plan Name _____ group # _____

Address of ins _____

Phone # _____

Secondary Insurance

Subscriber name _____

Relation to pt _____

Address _____

SS # ____ - ____ - ____

Date of Birth ____/____/____

Employer _____

Dental Insurance Co. _____

Plan Name _____ Group # _____

Address of ins _____

Phone # _____

****Please give insurance cards to a staff member. We need a copy for your file****

INSURANCE: Insurance is a contract between you and your insurance company. We are not a party to this contract. We do not render our services on the basis that insurance will pay all of our charges.

We will bill your dental insurances(s) ,as a courtesy to you. If your insurance company requires a preauthorization, we can help you with obtaining a copy. Although we can estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for fees that are not covered by insurance.

PRE- ESTIMATES : Some pre-estimates may be sent to you directly and not our office. Please notify us of a pre-estimate you may have received so that we can help determine if your estimated coverage is accurate. Although we try to be knowledgeable about all insurance companies, it is the responsibility of the patient to understand his/her own policy coverage.

PAYMENT: Payment is expected when services are rendered, unless other arrangements are made in advance. A prompt payment courtesy is available for operative treatment over \$500.00. Our staff will be happy to discuss qualifications for this. We accept cash, checks, Visa, MC and AMEX and we participate with the Care Credit program. In the event of a **returned check**, you are responsible for any fees charged to us by our bank. We reserve the right to check your **credit rating** for financial arrangements.

FINANCE CHARGES: A **service charge of 1.5%** per month (equivalent to 18% per annum) will be added to your account for unpaid balances over 120 days. In the event that we must hire an **attorney or collection agency** to collect this debt, you will be responsible for the payment of all costs and expenses, including all court costs and reasonable attorney's fees.

MONTHLY STATEMENTS: A re-billing fee of \$2.00 **per statement** will be assessed for any balance carried past 120 days.

Signature of Financially Responsible Patient Or Guardian

Date