Our Financial Policies and your Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policies. This form will give you the needed information for when we are providers with your insurance as well as expectations when we are not providers with your insurance. Please be sure to read both sides of this form and sign the back.

We have contracts with some of the plans under the following companies:

Aetna Delta Dental Cigna Metlife United Healthcare Ameritas
Lincoln Financial Principal Reliance Standard Assurant

Patients with insurance for which we are contracted providers:

You are responsible for deductibles, co-payments, non-covered services, coinsurance and items "not medically necessary" by your insurance company. Please pay co-payments as services are rendered. The remaining balance should be taken care of within 10 days after receipt of our billing statement, which will be sent to you after we have heard from your insurance. If you or your insurance carrier makes payment exceeding your balance, any overpayment will be refunded. Payment for non-covered services is due at the time services are rendered.

We will file your insurance claims for you. It is your responsibility to present your insurance card and make co-payments at the time of service. If you do not have your insurance card or insurance forms, payment will be expected at the time of service; otherwise it will be necessary to reschedule your appointment.

For any procedures planned or recommended, a fee estimate is available to you before any procedure is done. If you would like an estimate before a procedure, it is your responsibility to ask, as this is easily available.

It is your responsibility to make payment directly to us for any elective cosmetic procedure. Elective cosmetic procedures cannot be filed to insurance.

Patients without insurance must make payments for care on the date of service.

If we are not contracted with your insurance:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a third party to that contract. As a service, our office will submit claims to your insurance company at your request. However, we consider the patient primarily responsible for the account.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". UCR is defined as usual, customary and reasonable fees for this region. Thus, most insurance companies consider our fees usual, customary and reasonable. This statement does not apply to companies who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Payment in full for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express. The receipt you receive at your visit for insurance billable services provides all the information you need to file a claim for reimbursement from your insurance company when attached to your completed claim form. We will be happy to help you process your insurance claim for reimbursement, if we have complete and current insurance information.

If you have any questions about our financial policies or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Divorced Parents: The parent who brings the patient to our office will be responsible for our professional fees unless specific alternate arrangements made in advance.

I have read and agree to the Financial Policy stated above that applies to me.

____________________________________ ____________________

Signature (Patient/Responsible Party) Date

As a courtesy to our other patients, we kindly request 2 business days notice when rescheduling appointments.

Any patients who do not honor this policy will be asked to pre-pay their entire appointment fee when scheduling.

____________________________________ ____________________

Signature (Patient/Responsible Party) Date