OFFICE POLICY

Dear Insured Patient:

As a courtesy to you, our office is happy to help you utilize your dental insurance by filing your insurance claim for you. We will complete the claim form and file it with your insurance company the same day of your visit. You will receive a monthly statement from our office until all of the charges are paid. This will help you to know if your insurance company is taking more than the appropriate 30 days to process your dental claim.

Most insurance companies will not provide us with their specific guidelines, such as "usual and customary" price limitations for each procedure. **It is your responsibility to know if there are any waiting periods or limitations on specific procedures.**

Using the general breakdown of coverage from your insurance company, we **estimate** what portion of the charges are due from you. You are required to pay this portion at the time of service. Please keep in mind that these calculations are **estimates** of what your insurance company will cover. It is **NOT** a guarantee that they will pay that amount. We make every effort to get as close as possible to the covered amount, however it is impossible to know exactly what your insurance company will pay until payment is received.

The state mandates that insurance companies process all claims within 30 days of having received them. If a claim is over 30 days old it is your responsibility as the insured to contact your insurance company. Once your insurance company denies a claim or delays payment pending contact from you, the balance will then be due from the guarantor. If the insurance company does not respond to the claim within 60 days the balance will then be due from the guarantor. We will notify the guarantor of this balance and payment must be made immediately.

By signing this document:

1. I agree to authorize payment of benefits directly to this office.

2. I agree to the release of all necessary information to be provided to my insurance carrier and its representatives.
3. I understand these office policies and agree to be financially responsible for my account as well as any unpaid balances due to non-payment by my insurance company.

_____ _____

Relationship to the Patient Name if not the Patient

_____ _____

Patient or Guardian Signature Date