INSURANCE POLICIES

Our Professional treatment is rendered to you, not the insurance company. You are responsible to us for the obligation of payment of treatment. We will file your insurance as long as you can go to the **Dentist of your choice**. See our **Frequently Asked Questions section on Insurance Policies** for further information.

Please understand that your insurance policy is a contract between you and your insurance company. Any problems with non-payment or delay of payment is your responsibility

Remember, dental benefits were never meant to determine your dental care; they are to assist the patient in the payment of your treatment choice.

We must have a completed and signed insurance form.

You are responsible for portions not covered by your policy on the day of service.

Any insurance balance over 60 days old is delinquent and is your responsibility to pay.

Accident Insurance cases will be handled by the patient paying for treatment at the time of service and your insurance will reimburse you.

Please remember that we are not responsible for determining what your particular benefits are. Most policies cover what they consider a "usual and customary fee." However, the insurance company establishes these fees to meet their needs, and they are not always the same as the fees that may be charged in this office.

We will do our best to see that you receive your full benefits. However, ultimate responsibility for payment is yours and financial arrangements must be defined before dental treatment begins.

DENTAL INSURANCE INFORMATION

Insurance Company:________________________________

Address:________________________________

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Phone#________________________________

Employer Name: ________________________________

Address: ________________________________

Insured SS#:________________________________

Group #:________________________________

Plan #: ________________________________

Supervisor Phone#:________________________

ASSIGNMENT OF BENEFITS

I authorize payment of dental benefits to the named provider for professional services rendered.

Signed:________________________________

Date:________________________________

RELEASE OF INFORMATION

I authorize the release of any dental information necessary to process this claim.

Signed:________________________________

Date:________________________________