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FINANCIAL POLICY
For Patients with Dental Insurance

Our experience with over 500 different dental insurance contracts shows us misunderstandings most often occur concerning co-payment. Please read the statement below and sign. Thank you.

I understand my dental insurance carrier may pay for only a portion of my treatment. If this happens, I understand it will be my responsibility to pay the difference. It has been explained to me no contracted fee arrangement exists between this office and my dental insurance carrier.

Predetermination for treatment can be obtained in writing or over the phone if requested by the patient. Insurance companies however only consider these as estimates. I authorize this office to submit claims on my behalf either electronically or by mail.

If the insurance company does not make payment by 60 days after treatment, I will assume responsibility for full payment and deal with the insurance company myself. If my account becomes over 90 days past due I understand that interest and/or collection fees may be added to my account.

By signing this form I realize that this agreement supercedes any I have with my insurance carrier. These conditions pertain to all family members and individuals listed under my account.

Signature:__________________________ Date:________________________