Patient Financial Responsibility Form

FINANCIAL ARRANGEMENTS & DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance or benefit plan, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time treatment is provided. We accept cash, check, VISA, MasterCard, American Express and Care Credit. We will be happy to help you process your primary insurance claim for reimbursement. Please keep in mind we are here to help you submit any needed claims to your insurance to receive payment. **We do not keep up with your benefits or maximums for the year. That is your responsibility.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is extremely important that you understand the following:

- Your insurance is a **contract between you, your employer, and the insurance company**. We are not a party to that contract.
- Most insurance companies have a deductible that must be met before the company will pay their portion. If you have not met your deductible for the year, you are responsible for any charges until that deductible is met. Even after the deductible is met, most plans will only pay a percentage (usually 50-80%) up to the maximum yearly allowance. You will be responsible for the remainder.
- **Not all services are a covered benefit in all contracts**. Some insurance companies arbitrarily select certain services they will not cover.
- We must emphasize that as a dental care provider, our relationship is with you, not your insurance provider. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are provided.

A NO SHOW Fee of $50.00 will be applied to your account for any scheduled appointments that are missed without the courtesy of a phone call. We do **require a 24 hour notice** to cancel appointments or make any changes.

I understand that I am responsible for all debts incurred. If my account is assigned to a collection agency, I understand that I am responsible for all attorney fees, courts costs or delinquency fees that may be incurred during the collection of my debt. I understand that the delinquency fee will be equal to 50% of the principal amount owed.

Signature of responsible party   Date

Dental Insurance Information:

Policy Holder Name: ________________________

Date of Birth: __________________________ SSN: ____________________

Name of Insurance Company: ____

Employer: __________________________ or Self Plan Yes_____

Group Number: _______________________

Member ID: __________________________

Phone Number for Insurance: ______________________

*Please make sure you are providing your **Dental insurance** and not your Medical.

Give a copy of your insurance card to the front desk or have them make a copy of your card.