

Insurance Financial Policy

Our Goal in discussing financial arrangements relative to your dental needs includes:

- To inform you of treatment alternatives
- Their respective advantages and disadvantages
- The consequences and/or risks of limited delayed treatment and/or non-treatment

Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render services on the assumption that the charges will be paid for by an insurance company.

Unfortunately, insurance benefits will almost be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a predetermined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which your insurance agreement allows. However, this should not have control over what is in your best interest as far as treatment is concerned.

For your convenience, we will estimate the portion of the fee that your insurance company will not cover. **This is just an estimate.** After your insurance benefits have been paid, you are responsible for the unpaid balance. We will ask you to bring with you at the time of treatment the estimated uncovered portion of the total fee.

It is not possible to know exactly what your insurance covered will be prior to the treatment, as treatment sometimes changes. We can predetermine your benefits with your insurance company; however, this delays treatment 4-6 weeks or longer, waiting for the insurance company to respond, which may not be in the best interest of your oral health.

Our policy, and most dental plans, requires a percentage fee, (co-payment) to be paid at the time of your treatment. Full payment is required at the time of service if you are not covered by a dental plan.

Payment Options:

- Cash
- Check
- Visa, Mastercard, or Discover
- Care Credit (OAC)

I authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay an uncovered balance. I hereby authorize release of information for insurance purposes.

Signature of Patient (or Guardian)

Date