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OFFICE FINANCIAL POLICIES and ASSIGNMENT AUTHORIZATION

"Insurance Authorization for Submission of Claims and Assignment of Benefits"

Your complete dental care is of our utmost concern. As a condition of your treatment by this office, financial arrangements must be made in advance. All dental services performed without previous financial arrangements must be paid for at the time services are performed. Payment and Insurance co pays are due at the time of treatment. We accept:

1. Cash or Check
2. Major Credit Cards
3. You may pre pay towards any large treatment
4. Or apply for Line of Credit with CareCredit

The above (LOC) are financing options offered with low monthly payments for any dental treatment. Approval takes a few minutes and we will be glad to process your application with them immediately. They also offer same as cash options and extended monthly financing if treatment costs fit their criteria. We would be happy to explain these offers.

You are solely responsible for your account. We collect your estimated co pay/deductible at the time treatment is rendered. Any unpaid balance remaining after your insurance company pays will be billed to you. All insurance benefits and limitations are strictly between you and your insurance company. We encourage you to call your insurance to verify your coverage and follow up on unpaid claims after 30 days. As a courtesy we submit all insurance claims, we are a select provider for a few plans.

In order to submit insurance, we must be supplied with your accurate insurance information. It is not our responsibility to know your plan(s) Restrictions, Limitations, and Benefit Fee Schedules.

Appointment times are *reserved* for you and your needed care. If unable to keep an appointment, kindly give 24 hours notice. **Otherwise we reserve the right to charge $50.00 an hour for the time reserved.**

SIGNATURE: _____ DATE: _____

Insurance Assignment of Benefits

Your signature authorizes the healthcare provider named above to submit claims for payments for services to the insurance companies on your behalf and in your name, and assign to such provider the group insurance benefits otherwise payable to you, but not to exceed the provider's actual charges for the covered services.

I authorize the release to my insurance company or companies any information including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for treatment provided.

I understand that I am responsible for any fees my insurance does not pay and that any balances will be paid in full upon receipt.

SIGNATURE: _____ DATE: _____