



Financial Policies

Our office is happy to help you file your insurance claims to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what they allow for each service, regardless of what the actual fee might be. Your Employee Benefits Department can usually help you become familiar with your plan and any restrictions; and our office will assist you in maximizing your benefits.

Our responsibility:

1. To complete your insurance forms and submit them to your carrier for you in a timely manner.
2. To use current American Dental Association coding for correct reporting of procedures.
3. To accept direct payment from your carrier and keep track of account balances.
4. If necessary, to re-file your insurance claim a second time within a sixty (60) day period.

Your responsibilities:

1. To pay fees not covered by your dental plan.
2. To provide our office with the necessary information concerning your insurance coverage to allow correct filling of claims.
3. To understand that your dental plan is a contract between you, your employer and the insurance carrier. Our office will do all that we can to facilitate claim payments, but we do not have the power to make your dental plan pay.
4. To pay any account balance not paid by your insurance after two (2) billing attempts.

We thank you for choosing Advanced Care Dentistry and will do all we can to help you obtain the benefits you deserve. Please sign this form below. We will keep one copy in your chart and will give you a copy for your records.

I hereby authorize payment from my insurance company to be paid directly to the dental office for benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment, with or without dental benefits reimbursement. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental /medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Patient Name

Date

Signature of Patient or Responsible Party