DENTAL INSURANCE INFORMATION:

Patient Name (please print): _____

DO YOU HAVE DENTAL INSURANCE? YES _____ NO _____ (Please sign next page)

Insurance Company's Name: _____

Name of Insured: _____

Employer of Insured: _____

SS # of Insured: _____

Birth Date of Insured: _____

Relationship to Insured: _____

DO YOU HAVE DENTAL CO-INSURANCE? YES _____ NO _____ (Please sign next page)

Insurance Company's Name: _____

Name of Insured: _____

Employer of Insured: _____

SS # of Insured: _____

Birth Date of Insured: _____

Relationship to Insured: _____

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policies is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

If you do not have insurance or your insurance is an out-of-network United Concordia plan, we expect payment in full for all treatment at the time of service unless other arrangements have been made. We accept cash, checks, VISA, Discover and Mastercard. We now offer the option of using CARE CREDIT, a convenient, low minimum payment program for necessary or elective treatment not covered by insurance.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. Your insurance claim will **ONLY** be completed and submitted if we are provided with all pertinent insurance company information. It is ***your responsibility*** to verify that your policy is in force on your date of service. Otherwise, you are responsible for payment at the time of service.

Insurance is an agreement between you and your insurance company. We file insurance claims as a courtesy to you. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurances, "usual and customary" charges, etc., other than to supply necessary factual information. **Deductibles, co-payments and out-of-network United Concordia charges are required at the time of service**. **You are responsible for the prompt payment of your account**. If payment is not received from your insurance company within 90 days, the balance on the account becomes your responsibility.

LATE CANCELLATION/FAILED APPOINTMENT POLICY

We reserve the right to charge a failed appointment fee for any broken or cancelled appointments, when given less than 24 hour notice.

AGREEMENT

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and agree that a monthly finance charge of 1.5% may be added to my account if my balance is not paid in full within 30 days. I understand and agree that my account may be turned over to the Credit Bureau for collection after 90 days and that a 30% collection fee will be added to my account.

I have read and agree to comply with the office payment policy, insurance policy and late cancellation/failed appointment policy.

Patient's/Parent's Signature_____Date_____