

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

If you are a student, name of school/college: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Assignment of Insurance Benefits and Release of Information

I, the undersigned, certify that I (or my dependants) have dental insurance coverage with _____
Name of Insurance Company

and assign directly to Monica Lee, DDS all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance whether manual or electronic.

Responsible Party Signature _____ Date _____

Our Office and Financial Policies

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

APPOINTMENTS

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care, and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, a **48-hour notice** is expected. A fee may be applied for appointments missed without notice. Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

INSURANCE

As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, **we do require you to pay your deductible and/or "estimated patient portion" at the time of service.** The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card and a claim form if needed. We must be able to verify coverage before we can accept assignment of benefits. Please note that dental insurance plans are different from your medical insurance. Each plan has different yearly deductibles and benefits. Most insurance plans will pay, at most, 80% of Basic procedures and 50% of Major procedures. When possible, we will submit a dental pre-estimate to your insurance company for review. This will allow you to know the exact amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I am responsible for reading and understanding my dental insurance benefits._____

initial

USUAL AND CUSTOMARY RATES

Please be aware that some of our services may be "non-covered", subject to an insurance company's arbitrary determination of usual and customary rates, or have time limitations imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. **You are responsible for any balance left unpaid by your insurance company.** The adult accompanying a minor is responsible for full payment.

PAYMENT OPTIONS AND ACCOUNT INFORMATION

In order to maintain our fees at a reasonable level, we do not send monthly statements. If a balance is over 30 days, a billing fee will be charged at the rate of 1.5% per month of the total balance, or \$7.00, whichever is greater. In the event we receive a returned check for insufficient funds or a closed account, there will be a \$35.00 fee charged to your account. Collection fees of 35% of the account balance will be added to any balance turned over for collection purposes.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA and MASTERCARD

Thank you for understanding our guidelines. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above office and financial policies.

X _____
Signature of patient or responsible party

Date