



# COMPLETE PREVENTIVE DENTISTRY, INC

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## VITAL INFORMATION ABOUT YOUR DENTAL INSURANCE

Our office is happy to help you file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can 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 it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built into most plans and their required payment is strictly regulated by state law. Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions, and our office will assist you in maximizing your benefits.

### Our Responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment.
2. Use current ADA coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance claim a second time within a 60 day period.

### Your Responsibilities:

1. To pay plan deductibles and co-payments not covered by your plan at the time of treatment. We do our best to estimate your out of pocket cost, however, this is just an **estimate**. A balance may still remain after your insurance pays according to plan benefits.
2. To provide our office with necessary information to submit a claim form of your behalf.
3. To understand that your plan is a contract between you and your employer and the insurance carrier. Our office simply submits the claims as a courtesy for you.
4. To pay any account balance that may remain after insurance has paid by the due date on your monthly statement.

We thank you for choosing our office 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 we will provide a copy for your records.

**I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.**

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Patient or Insured

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Date