

FINANCIAL ARRANGEMENT

FOR THE OFFICE OF TERRY TEST, D.D.S.

As a courtesy to our patients, Dr. Test will gladly accept assignment of your dental insurance. Our office feels that this is a service that benefits you greatly but can cause some confusion. Please read the following information provided to help you understand your benefits and the manner in which insurance is accepted and filed in this office.

1. In order for our office to file your dental insurance we must have all pertinent information on your employer and/or dental insurance carrier. This includes addresses, telephone numbers, group numbers and current insurance identification card. A claim form is most times not necessary as we file all claims electronically. **Initial** _____
2. **The responsible party in your family (or on the account) is responsible for the deductible and any co-payments or portions not covered by your insurance. THIS IS DUE AT THE TIME OF SERVICE.** **Initial**_____ **We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.** **Initial**_____
3. We are **not** contracted with any insurance companies. However, we will accept assignment of benefits for **60 days**. If at the end of this time payment has not been made by your insurance carrier the responsibility of any unpaid portion will be that of the patient or responsible party named on the account. This includes any claims that are denied and any portions considered in excess of what the carriers considers UCR. **Initial** _____
4. If your dental insurance changes please inform us prior to any scheduled appointments. **Initial** _____
5. Payment in full is expected at the time of service for all new patient emergency exams. **Initial** _____

Dental insurance can be confusing and frustrating for all involved. Should you have questions or concerns please do not hesitate in asking one of the business office staff for help. **Initial** _____

6. Should you need to cancel an appointment, we ask that you notify the office 24 hours in advance. We understand that emergencies may arise, however, should your appointment be confirmed and you have not notified our office to cancel, there will be a fee for the failed appointment. **Initial** _____

Method of Payment: Cash, Check, Visa, MasterCard, Discover, and Care Credit

OUR GOAL IS TO ASSIST YOU IN ANY WAY POSSIBLE TO MAKE SURE THAT YOUR DENTAL INSURANCE BENEFITS ARE MAXIMIZED.

SIGNATURE OF RESPONSIBLE PARTY

DATE
