Because dental insurance companies have become increasingly difficult to work with, we have been forced to establish a policy which does not place us in a constant confrontational role.

It is your dentist’s responsibility to **recommend what you need**. All recommendations are based on diagnostic (X-rays) and clinical exams and pictures and presented to you by your dentist or by the office manager. Your dentist will give you options (if any) for the treatment recommended, will answer all questions you might have about it and will help you to decide what treatment would be the best for you. ___ (Initialize)

When your office visit is completed, the receptionist will enter the charges into the computer. You will be asked to pay an **estimated** amount for the service provided. Our estimate is a guess based on the information provided by the insurance representative over the phone. *The information given to us is not a guarantee of payment or approval for the treatment recommended by your dentist.* ___ (Initialize)

If you carry a supplementary or secondary Insurance Plan, we will help you with both Insurance claims, but we still will follow our Policy to collect deductible, coinsurance, and pre-payment. ___ (Initialize)

If you are interested in following the doctor’s recommendation and need to know exactly how much your Insurance plan will pay, a pre-treatment estimate will need to be filed. We will file a patient treatment pre-estimate to their primary insurance **upon the patient’s request** before the treatment is begun. ___ (Initialize)

We will send a dental claim on your behalf and we will answer any questions your Insurance Company may raise about diagnosis or treatment in an appropriate, timely manner. *It is important that you understand we are not part of the relations between you and your insurance. If the insurance denies benefits for patient’s treatment for any reason, the patient is financially responsible for all charges and for the outstanding balance on the account. We are unable to “force” an insurance company to fulfill its obligations to you.* If the insurance company does not pay for your treatment in a reasonable period of time (more than 90 days) you, the patient, are responsible to pay the balance off. All credits if any will be returned to the patient upon receiving final payment from the insurance. ___ (Initialize)

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FROM SERVICES RENDERED by Deer Park Dental, Ltd.

PRINT NAME ___________________________ (PATIENT/SUBSCRIBER, if minor – a GUARDIAN)

SIGNATURE _____________________________ DATE __________________