St. Mary Dental

Patient Name: ______________________________ CONFIDENTIAL
DOB: __________ Chart #: __________

# Insurance Authorization

## DENTAL INSURANCE INFORMATION

Understanding insurance coverage can be quite challenging. Our goal is to maximize your benefits. We care for patients from many different employers and plans. Each employer pays an insurance premium for specific coverage, which fits that company's budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, limitations, deductibles and required co-payments or co-insurance.

## OUR COURTESY SERVICE TO YOU INCLUDES:

1. Filing insurance claims within 24 hours of your visit and requesting payment of benefits be sent to this office.
2. Assisting in researching your dental insurance plan to determine available benefits.
3. Re-filing your insurance promptly, as needed, if insurance company requests additional information.
4. Following the American Dental Association guidelines for coding procedures and insurance filing.

## OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY:

1. Payment of fees not covered nor paid by your insurance plan are due at the time services are rendered/delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from the insurance company.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the insurance contract with the employer and not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 45 days.
5. Keeping our office informed of any changes in your insurance coverage, home address or employment.
6. Understanding that amounts and fees regarding treatment and insurance benefits are an estimate and are subject to change.

**Primary Insurance Information:**
Subscriber Name: ______________________ Relationship to patient: ______________
Social Security #/ID #: ____________ Birth Date ____/____/____ Group/Local #:__________
Employer Name:__________________________________________

______________________________________________________
*Address* *City* *State* *ZIP*
Insurance Co Name ______________________ Phone # (____) ______________
Insurance Co Address:______________________________________
*City* *State* *ZIP*

**DO YOU HAVE SECONDARY DENTAL INSURANCE?** Yes No *(if yes, please complete the sec. ins. Info)*
**Secondary Insurance Information**:
Subscriber Name: ______________________ Relationship to patient:______________
Social Security #/ID #: ____________ Birth Date ____/____/____ Group/Local #:__________
Employer Name: __________________________________________

______________________________________________________
*Address* *City* *State* *ZIP*
Insurance Co Name: ______________________ Phone #: (____)______________
Insurance Co Address: ______________________________________
*City* *State* *ZIP*

Thank you for your cooperation. Please sign below and have your insurance card ready for us to make a copy to keep in your file.

I hereby authorize Dr. Saeda Basta and St. Mary Dental Staff to release to my insurance company information acquired in the course of my dental care for the purpose of determining insurance benefits and obtaining payment for services. I hereby authorize benefits to be paid directly to Dr. Basta. I authorize the use of my signature on all insurance submissions. I understand that I am responsible for any unpaid balances, regardless of estimated quotes. Unpaid balances will accrue a 1 ½% per month service charge (18% annual) until paid in full.

______________________________________ ______________
Signature of Insured/Subscriber or Legal Guardian Date