AUTHORIZATION FOR SIGNATURE ON FILE AUTHORIZATION OF PAYMENT/RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

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 benefits plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay towards 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 in to most plans and their required payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. 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. Use current American Dental Assoc. coding for correct reporting of procedures.
2. Accept Direct Payment from your carrier and keep track of balance.
3. If necessary re-file your insurance a second time within a 60 day period.

YOUR RESPONSIBILITIES

1. To pay fees not covered by your plan at the time of treatment.
2. To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
3. To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment but we do not have the power to make your plan pay.
4. To pay any account balance not paid by insurance after 2 billing attempts.

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 will give you one copy for your own 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 cost of dental treatment. I grant the right to the dentist to release my dental history and other information about my dental treatment to third party payers.

Patient: _____ Date: _____

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