

**INSURANCE AGREEMENT**

We strive to provide our patients with optimum dental treatment in the most comfortable and caring environment, and we make every effort to help our patients receive the maximum benefits from their insurance company for our services. To help us accomplish this for you, it is necessary that you provide us with complete and correct insurance information so filing your claim can be handled promptly and accurately.

It is your responsibility to be informed about your dental benefits. The employer (or agent, for individual policies) that your coverage is through should provide you with detailed information about what your benefits are and how your benefit program works. You should also have a customer service number on the back of your ID card that you can call for assistance.

* Please present your insurance card and ID when you arrive. Failure to do so could result in an additional out of pocket cost to you at the time of service.
* You will be given a treatment estimate for your co-pay prior to any treatment. Your co-pay is due and payable at the time of service. Our office does have the ability to reschedule any non-emergency appointments when patients are not prepared to pay their co-pays.
* If our office is unable to verify eligibility of benefits prior to services being rendered, you will be asked to pay the charges in full and we will reimburse you after the verification is obtained.
* As a courtesy to you, we will file your insurance claims based on the information provided to us by your insurance company, and estimate what your portion will be. **Your estimated portion is due at the time services are provided.**
* They are responsible for paying your claims within 60 days. If their payment is delinquent, it is then respectfully your responsibility to pay your remaining balance.

**I acknowledge that I have completely read the above statement and hereby agree that I am responsible for my outstanding balance not paid by my insurance company.**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**