Understand Your Insurance

Dear our Valued Patient:

We have prepared this letter to help you understand the complexities of dental insurance, realizing how confusing it can be. Insurance companies and employer plans vary significantly in how they administer dental benefits. We strongly urge you to know what deductibles, co-payments, visit and/or benefit limitations, authorization requirements, and exclusions your plan may include. ***There is no way that we know exactly what and how much your insurance will cover for your treatment. We do our best to give you the closest estimate before and at the time of treatment. After treatment, we will submit a claim to your carrier. Then, we will receive an Explanation of Benefits (EOB) from the plan. We will finally use this EOB to determine your responsibility for full payment.*** You should review the EOB that is sent to you by the plan carefully. If you feel that they have made in error in administering your benefits, please call them directly to have it corrected. It should be understood that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve your. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

Sincerely,

Signature of Patient or responsible party Print Date

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Financial Policy

To our Valued Patient,

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The followings are statements of our Financial Policy which we require you to read and sign prior to any treatment.

1. Payment for services must be made at the time of visit, unless previous financial arrangements have been made. Payments may be made by cash, credit card or through our financial companies for easy monthly payments (credit approval is required).

2. Custom made items such as crowns, bridges, partials, etc., take more than one appointment. In the event a patient does not come in for the completion of their treatment, payment in full is still due.

3. Patients having dental insurance will be asked to pay their deductible and **estimated portion** of the fee at the time services are rendered and will also be responsible for any balance remaining after the insurance company has paid the claim.

4. While the filing of insurance claims is a courtesy that we extend to our patients, we must emphasize that as dental providers, our relationship is with the patient, not the insurance company. If we do not receive payment from your insurance company within 60 days, payment becomes your responsibility.

5. Unpaid accounts will not be held over 90 days and will be turned over for collections without notice.

6. Time is set aside specifically for you when you make an appointment. Therefore, a minimum of 2 business days notification is required if you are unable to keep your appointment. Patients canceling without a 2 business day notice or who do not show up for their appointment will be charged a broken appointment fee of $50.00.

7. Cancellations left on our voice mail service after hours will not be accepted if within this 2 business day requirement.

8. We expect that you will notify our office immediately any change of address, employer/insurance carrier. It is patient's responsibility to take care of any outstanding balance that may occur without notification of change of benefits.

9. I authorize the release of any information relating to my dental care. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Berkeley Lake Dental of the group insurance benefits otherwise payable to me.

10. I agree to pay all cost of collections for any outstanding amounts to my account including a reasonable attorney fee. I understand this may increase my outstanding charges by 20%.

I have read the above financial policies and agree to abide by them.

Signature of Patient or responsible party Print Date

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