VI Dental Center Insurance and Office Policy

Insurance Policies

- ☐ There is no direct relationship between this office and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits; dental insurance policies vary. While it is your responsibility to understand your insurance policy, we will do what we can to help you understand and maximize your insurance benefits. We ask that you be responsible for the payment of all treatment at the appointment when treatment is rendered. This office will generate and submit an insurance claim to your insurance company for payment/or reimbursement. Filing a claim with your insurance company does not relieve you from the responsibility of payment of all charges. Overdue/unpaid accounts will be subject to collection actions. The patient or guardian will be responsible for collection agency, attorney, court and all associated fees incurred by VI Dental Center._____ **(Initial)**

- ☐ While we always strive to optimize the use of dental benefits to minimize you're out of pocket cost, most plans have a yearly allotment maximum ranging from $1000-$2000. Additionally, most dental plans do not cover the costs of major reconstructions such as implants or cosmetics dentistry, braces for adults, or work deemed by the plan to be "cosmetic._____
  (Initial)

- ☐ Your dental plan provides you coverage for many services, but your plan deductible amount *must* be paid at the time of service if treatment ranges from the following:
  - **Preventive** (ineligible for full mouth x-rays and/or comprehensive evaluation)
  - **Cleanings** (full mouth debridements or scaling and root planning)
  - **Basic care** (fillings, extractions, or basic restorative work)
  - **Major services** (bridges, crowns, root canals, dentures, or implants)._____
    (Initial)

- ☐ Waiting for insurance payment is a courtesy provided by this dental practice. We reserve the right to withdraw this courtesy at any time. We will bill your dental insurance provider(s) and accept assignment of benefits during your dental treatments. Direct assignment will be discontinued if patient's yearly allotment has been satisfied or recommended treatment is complete._____
  (Initial)

- ☐ The insurance provider(s) are billed when treatment is rendered. It is your responsibility to supply this office with any changes to plan coverage (including cancellations), and changes with dental insurance carrier._____
  (Initial)

- ☐ If you receive payment from your insurance carrier during the period which VI Dental Center has accepted assignments of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the dental office. Failure to this may result in collection action. _____
  (Initial)

- ☐ If you discontinue your dental treatment for any reason other than completion of your treatment plan, you will be responsible for any unpaid balance regardless of any claims submitted to your dental insurance provider, at the time you discontinued care. _____ **(Initial)**

- ☐ This dental office does not promise that an insurance company will pay. If payment is denied by an insurance carrier for any reason, patient and/or insured agrees to accept financial responsibility for payment of all unpaid portions._____ **(Initial)**

Broken Appointment Policy

- ☐ Your appointment time has been reserved especially for you. If you are unable to keep your appointment, please notify us at least 48 hours in advance. As a courtesy to our patients, we will attempt to confirm your appointment, but it is the patient (or guardian) sole responsibility to keep scheduled appointment. Broken appointments or appointments with less than 24 hours notice will be charged $50.00._____ **(Initial)**

Office Payment Policy

- ☐ The best doctor/patient relationships are maintained when there is a complete understanding of the treatment and the fee. Upon your first office visit, the cost for services rendered is due in full. Your insurance will be filed for benefits due and you will be reimbursed. Upon your following office visits we ask that you pay 60% of all procedure costs at the time of service if you have active dental insurance coverage; otherwise payment is due in full._____ **(Initial)**

Office Fee Policy

- ☐ A fee of $75.00 will be charged for insufficient funds/returned checks._____ **(Initial)**

I have read and understood the above insurance policy and wish to participate in the dental office policy. I hereby agree to abide by the provisions as specified above.

_____	_____
Please Print Name of Patient	Please Print Name of Person Responsible

_____	_____	_____
Patient / Guardian Signature	Relation to Patient	Today's Date