Vital Information About Your Dental Insurance

As a courtesy to you, we will be happy to file claims on your behalf to **your** dental insurance. Your dental insurance is a contract between **you** and **your insurance carrier**. Dental benefits/coverages can vary greatly depending on the carrier. Many carriers have different coverages for dental procedures. Some may be covered fully, partially, or not covered at all. It will be **your** responsibility to understand your dental benefits/coverage information. This may include, but may not limited to, whether or not our practice is an "in-network" provider for your dental insurance carrier.

Your dental insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Therefore, even though insurance companies sometimes estimate to cover at 100%, they may actually only cover 100% of their usual-and-customary fee(s) and may not cover our practice's full fee(s).

Your employer's Benefits Administrator can assist you in becoming familiar with your plan's benefits and restrictions. Our team will always assist you in trying to maximize your dental benefits and give you the most accurate ESTIMATES possible.

OUR REPONSIBILITES:

1. Complete your insurance claim form(s) and submit them to your carrier for you within 24 hours of treatment.
2. Follow-up with your insurance carrier regarding any claim questions.
3. Accept direct payment from your insurance carrier and keep track of any balances.
4. If necessary, re-file your insurance for a second time within a 60-day period.

YOUR RESPONSIBILITIES:

1. To pay the **ESTIMATED** fees for any amount not covered by your dental insurance **at the time of treatment**.
2. To pay any account balance not paid by your dental insurance.
3. To provide our office with all current insurance information and notify us with any changes in coverage to allow correct filing of claims.
4. To be aware of your plan benefit details.

I hereby authorize payment directly to McLeansville Family & Cosmetic Dentistry of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist/practice to release my dental/medical histories and other information about my dental treatment to third party payers.

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Signature of Patient or Insured

_____ _____

Printed Name of Patient or Insured Date