j Dailey, DDS
SMILE DAILEY
GENERAL & COSMETIC DENTISTRY

DENTAL INSURANCE POLICY

As a courtesy we will gladly file your claims and accept assignment with some, but not all dental insurance companies provided you agree to the following:

Initial:

_____ You provide us with an insurance card and/or all of the information necessary to verify your coverage and file your claim.

_____ Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company. ***** If you have any questions regarding your dental benefits, please contact your employer or dental insurance company directly.**

_____ We may estimate your insurance benefits, this is ***ONLY AN ESTIMATE.***

_____ Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is YOUR responsibility. Receiving our services indicates your acceptance of the responsibility to pay regardless of our estimate.

____ All charges not paid by your insurance company are your responsibility regardless of the reason for non-payment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

____ Treatment provided in another dental office during your current plan year may alter your co-payment due for services in our office. In such cases, we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company if this applies to you.

____ There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us but CANNOT guarantee what your out-of-pocket expense will be.

__ Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations.

I have read and understand this document in its entirety.

Signature of patient or parent / guardian: _____ Date:_____