SPRINGBROOK FAMILY DENTISTRY

FINANCIAL POLICY with DENTAL INSURANCE

- You need to bring your insurance card to your first visit and are responsible for informing us anytime there is a change to your dental insurance policy.
- We will always do our best to help you to maximize your benefits and will file all claims for you. However, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.
- In many cases, an insurance company's benefit check can be sent to our office directly. **In such cases, you are responsible at the time of treatment for your deductible and for your coinsurance estimate.** We will do our best to estimate this as closely as possible for you. In the case the amount due is underestimated, you will be sent a bill for the remainder following payment by your insurance company.
- Our staff is trained to help you with questions you may have relating to how your claim was filed, or regarding any additional information your carrier may need to process your claim. Please ask if you have any questions.
- Your claim will be filed immediately, and benefits are expected to be paid within 30 days. The filing of an insurance claim does not relieve you of timely payment on your account. **If the claim is not cleared by your carrier in 60 days, the unpaid portion will become your full responsibility.**
- **You are responsible for any amounts your insurance company chooses not to pay**, for whatever reason. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly.
- Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would provide all pertinent information which you may sign and mail.
- If you need to reschedule your appointment please call us with a **minimum of 24 hours' notice**. Appointments missed/cancelled without adequate notice are subject to a **$35 cancellation fee.**

I understand and accept the financial and the dental insurance policies listed above and have had all questions answered to my satisfaction.

Patient Name: _____

Patient Signature: _____

Date: _____