

PLEASE READ AND INITIAL THIS ENTIRE FORM

As a courtesy to our patients we bill Dental Insurance for services at our office.

_____ Insurance is an agreement between you and your insurance company. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. We DO NOT have access to negotiated and contracted fees specific to your group plan. Fees are established between the insurance carrier and the company or person purchasing the plan.

_____ PPOs (Preferred Provider Organizations) are like HMOs in that they have a network of dentists with whom they have a signed contract. Patients may choose a dentist on the PPO list, or choose a dentist outside the "network". Because an "in network" PPO dentist accepts a payment fee schedule, the patient's out of pocket expenses may be higher if he chooses to go to a dentist not associated with that particular network. An out of network dentist is under no obligation to accept the PPO fees. The difference may be minimal or large.

_____ A pre-determination of benefits can be sent on your behalf and per your request prior to beginning treatment. Please note that it will take up to 4 weeks to receive a response from insurance that determines an estimated calculation of benefits.

_____ All HMO's are considered out of network. We cannot bill HMO plans for services rendered at this office.

_____ **Estimated patient portion is collected in full the same day treatment is rendered.**

It is important for you to have a copy of your policy and some understanding of it. This document is our attempt to avoid any financial misunderstandings. In the end you are responsible for anything your insurance company does not cover for any reason.

Please complete the information below and present the most current Dental Insurance card for this account. Failure to present accurate and current information may result in claim denial due to timely filing policies set by your insurance.

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Relationship to Patient _____ Social Security # _____ Eligibility Date _____

Address _____

Employer Name _____

Insurance Company _____ Customer service phone number _____

Claim billing address _____

ID Number _____ Policy/Group Number _____

I have read, and understand the Davis Pediatric Dentistry Insurance/Financial policy.

Patient or representative signature _____ Date _____

Please contact our office if you have any questions regarding your account. (760) 942-1131 FAX: (760) 942-4868