INSURANCE DISCLAIMER

Insurance claims are filed as a courtesy to our patients. At each visit, we estimate the portion you are required to pay according to the information we have received from your insurance company. ***IT IS YOUR COMPLETE RESPONSIBILITY, REGARDLESS OF INSURANCE, TO PAY FOR ANY CHARGES THAT YOU INCUR AT OUR OFFICE.*** *If your insurance company does not pay the portion we have estimated, you are required to pay the balance due and contact your employer or insurance company with questions concerning your policy. Payments are expected within thirty days or a late fee/billing charge ($10.00) will be applied. A collection fee of $15.00 will be charged to past due accounts if they are sent to a collection agency. Any account with a remaining balance unpaid after ninety days will be charged any collection fees associated with your account.*

_____ _____

Signature **Date**

Name of Person with insurance_____

Their date of birth_____**and social security number**_____

Their place of employment_____**and phone**_____

Carrier ID #_____

BELOW THIS LINE IS FOR OFFICE USE ONLY

Verification date_____ **Verified by**_____ **Initials**_____

Patient name_____**and date of birth**_____

Insurance company_____ **Group #**_____

Phone #_____**Envoy/Payor #**_____**Electronic or Paper Claims**

Yearly ded $_____**Yearly max $**_____**Ded met?**_____**Max used$**____

Effective date_____**Calendar Year** _____ **Single or Family Coverage?**

Preventive_____**% Restorative**_____**% Major**_____**% RPS**_____**%**

Sealants_____**% Missing tooth clause?** _____ **Replacement clause?**_____

Implants _____ **FMXR / PAN**_____**(DATE OF LAST**_____**)**

Waiting periods? _____ **Occ guard**_____**% info.**____

Does insurance pay on seat date or prep date? (circle one)

Frequencies on cleanings/exams : 2 per calendar year __ **1 every 6 months**_____

Ortho_____