IMPORTANT DENTAL INSURANCE INFORMATION

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients with dental insurance from many different companies. Each employer pays an insurance premium for a specific level of coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy - exclusions, limitations, deductibles and required co-payments etc.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment be directed to the appropriate party.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of benefits available to you.
4. Re-filing your insurance a second time, if necessary, within 60 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan and anticipated co-payment amounts at the time service is delivered. So that you will be prepared, we will do our best to estimate this information in advance of your appointment.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from you insurance carrier or change the coverage that your employer has chosen.
3. Be aware that some dental insurance policies may restrict payment for some services, may directly reimburse the employee, or calculate the co-payments differently based on your choice of dentist. They may also use a restricted fee schedule (called UCR) and may exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
5. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation regarding your dental insurance coverage. Please feel free to ask us about any concerns you may have.

I hereby authorize Dr. Roman Shlafer to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Roman Shlafer. I understand I am responsible for any unpaid balance.

X _____ X **Date**_____

(SIGNATURE OF PATIENT/INSURED)