

OFFICE POLICIES & INSURANCE INFORMATION
PLEASE READ, SIGN AND DATE

Please be advised that we are **NOT IN-NETWORK WITH ANY INSURANCE COMPANIES EXCEPT DELTA DENTAL, CIGNA, ALWAYS CARE/STARMOUNT, GUARDIAN and HUMANA**

I understand that responsibility for payment for endodontic services provided in this office for my dependants or myself is mine, due and payable at the time services are rendered. As a courtesy to you, our office will file your insurance claim for you. However, You will be required to pay your estimated patient portion the same day that treatment is received. Sometimes your insurance policy will not cover all charges. In such cases you will be sent a statement for the balance due. Should the balance not be paid 30 days after the claim has been resolved, the outstanding balance is your responsibility. I understand that a \$35.00 fee will be assessed for all NSF checks. I further understand that a 1.5% finance charge (18% annually) will be added to any balance not paid within 30 days after treatment. In the event of default, I promise to pay interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note. I understand that a 24-hour cancellation notice of any scheduled appointment is required in order to avoid being charged \$50.00. I understand and agree to abide by the above policies.

INSURANCE INFORMATION

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

OUR COURTESY SERVICE TO YOU INCLUDES

- Filing your insurance for you within 24 hours of your visit and requesting payment of your benefit to our office.
- Electronically filing your insurance (when applicable) for short turnaround.
- Following ADA guidelines for coding procedures and filing insurance.

OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY

- Payment of fees not covered by your insurance plan at the time the service is delivered.
- Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
- Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
- Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage!

I hereby authorize Dr. J. Jared Harmon's office to release my insurance company information acquired in the course of my dental care. I also authorize benefits to be paid directly to Dr. J. Jared Harmon. I understand I am responsible for any unpaid balance.

SIGNATURE _____ DATE _____