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Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Insurance Phone #

OUR OFFICE POLICIES:

1. We ask that you pay for your initial consultation at the time of your visit. We accept checks, cash, Mastercard, Visa, Discover, Care Credit and Lending Club.
2. We reserve the right to bill patients for no-shows and cancellations with less than 24 hours notice.
3. As a courtesy to our patients, we are happy to file your primary insurance claims. Your account is your responsibility - not that of the insurance company. You will be billed for all services that your insurance company does not cover. In addition, if a filed claim is not paid by insurance within 60 days, all fees will be due.

I have read and understand the above policies and procedures. I authorize release of information to my insurance company for the purpose of dental claims. I further authorize payment directly to North Texas Periodontics and Implantology, PLLC of the benefits otherwise payable to me.

Signature _____ **Date** _____

FACTS YOU SHOULD KNOW ABOUT DENTAL INSURANCE:

Dental insurance is rapidly playing a larger role in helping people obtain dental treatment. Since we strongly feel our patients deserve the best possible dental care we can provide, and in an effort to maintain the high quality of care, we would like to share some facts with you.

1. Dental insurance is NOT meant to be a PAY-ALL, it is only meant to be an aid.

2. Many plans tell their insured that they will be covered "up to" 80%" or 100%". In spite of what you have been told, we have found that most plans cover 60% to 70% of an average fee. Some pay more. Some pay less. The amount your plan pays is determined by how much your employer paid for the plan. The less he pays for the insurance, the less you will receive.

3. It has been the experience of many dentists that some insurance companies tell their customers that the "fees are above the usual and customary fees" rather than saying to customers that "our benefits allowed are low".

4. Insurance companies do not cover many routine dental services. Sometimes there may be treatment you need that is not a "covered benefit" with your insurance. We do our best to estimate what insurance will contribute, however there is never a guarantee from insurance prior to treatment.

SOME HELPFUL DENTAL INSURANCE TERMS:

UCR (USUAL, CUSTOMARY, AND REASONABLE) - These are the maximum amounts that will be covered by the plan for eligible services. Exceding the plan's customary fee, does not mean that your dentist has over-charged for the procedure. There are no regulations as to how insurance companies determine reimbursement levels, resulting in wide fluctuation which may not reflect the fees that area dentists charge.

ANNUAL MAXIMUMS - This is the maximum dollar amount a dental plan will pay toward the cost of dental care within a specific benefit period, usually the plan year. The employer/plan purchaser makes the final decision on "maximum levels" of reimbursement through a contract with the insurance company.

PREFERRED PROVIDERS - These are providers who have a contract (are "in-network") with your dental benefit plan. Whether or not you choose to receive dental care from this defined group can affect the level of reimbursement.

TREATMENT EXCLUSIONS - A dental plan may not cover certain procedures or preventative treatments. This does not mean that these treatments are unnecessary. Patients need to be aware of the exclusions and limitations in their dental plan, but should not let those factors determine their treatment decisions.

NOT DENTALLY NECESSARY - The dental plan provides benefits for those services that IT considers to be dentally necessary. This does not mean that the services were not necessary. Only your medical & dental providers can help you decide what type of treatment is best for you.

PLAN FREQUENCY LIMITATION - Certain procedures may simply not be covered as often as necessary for optimal oral health. Limitations vary depending on the contract purchased by your employer.

EXPLANATION OF BENEFITS (EOB) - An EOB is a written statement to the beneficiary after a claim has been reported, indicating the benefit/charges covered or not covered by the dental benefit plan.

Response Date: _____