SCHMITT DENTAL

Dental Insurance Policy

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or payment amounts prior to any visit. **Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.** We will check your insurance eligibility and benefits 1 to 2 days prior to service as a courtesy to you. However, you are responsible to know your policy guidelines.

- Some insurance companies downgrade services, they determine if they will pay for a less costly service than the covered service performed by the dentist. For example, composite fillings and porcelain crowns may be downgraded to amalgam fillings or full metal crowns. The difference between the service that was performed, and the less costly service then become your responsibility. Any co-payment that is collected at the time of your visit is an **ESTIMATE**. Please understand that it is fully ultimately your responsibility to find out if your insurance is in or out of network with our office.
- As a courtesy, we will file your insurance claim for you at the time services are rendered.
- Patients are expected to provide complete and accurate insurance information prior to their appointments. This includes insurance company name, group name, member ID, group name, insurance provider phone number, and claims address.
- You have the right to request a predetermination for any treatment needed if you want exact pricing.

To find out what your insurance plan covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

Acknowledgement: I acknowledge I have read and fully understand my insurance responsibilities and have had all my questions answered. I do hereby expressly guarantee payment in full of all charges incurred for services rendered or to be rendered to me. Further, I agree to pay all attorney fees and court costs incurred by Schmitt Dental in the collection of amounts for which I am responsible. I understand that a copy of this agreement is available upon request. I authorize the release of any dental, medical or other information necessary to process this health insurance claim. I also request payment of benefits either to myself or to the party who accepts assignment. I authorize payment of dental benefits to the provider for services provided.

Sign _____ **Date:** _____

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