



FINANCIAL GUIDELINES

We are committed to providing you with the highest quality of orthodontic care. We also want to serve you in a manner which is as comfortable and pleasant as possible. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss proposed treatment, give you an estimate in writing, and provide an initial insurance estimate. If you have orthodontic insurance we will assist you in receiving your maximum allowable benefits.

We cannot emphasize too strongly that the extent of your insurance benefits is defined in a contract between you, your employer and an insurance company. Insurance decisions are made by you and your insurance provider. If for any reason your insurance company does not pay the estimated amount, it becomes your financial obligation. As a courtesy, we will contact your insurance for an initial estimate. It is your responsibility for the accuracy of the estimate and for any changes you or your insurance provider may make to your policy. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claim form and sending it in promptly. Our preferred method of payment is automatic withdrawal from your checking or savings account. Payment by credit card, checks and cash can also be arranged.

We realize that a temporary financial crisis may affect timely payment of your account. If such an event does develop we encourage you to contact our office immediately. By keeping the lines of communication open, we can avoid any misunderstandings that would interfere with our positive relationship.

Patient Name _____ Date of Birth _____

PRIMARY Dental Insurance

Insured's Name: _____

Relationship to Patient: _____

Insured SS#: _____

Insured's Birth date: _____

Insured's Employer: _____

Insurance Co. Name _____

Group #: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Orthodontic Coverage: Yes No

Patient/Parent Signature _____

SECONDARY Dental Insurance

Insured's Name: _____

Relationship to Patient: _____

Insured SS#: _____

Insured's Birth date: _____

Insured's Employer: _____

Insurance Co. Name _____

Group #: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Orthodontic Coverage: Yes No

Date _____