STATEMENT OF POLICY REGARDING INSURANCE COVERAGE AND BILLING

If you have an insurance plan that will pay a portion of your orthodontic treatment, we will be happy to assist you in claiming your benefits. With increasing numbers of dental insurance programs, we find it very difficult to have a complete and accurate knowledge of all programs. Therefore it is in your best interest to research your specific contract and available benefits.

Since we have no say in the selection of your insurance company (nor do we feel we should), we have no control over the terms of your contract, the method of reimbursement, or the determination of your insurance benefit. We cannot influence the amount of your insurance benefit by manipulating the information in your report. Our report is a true and factual statement of the information requested by your insurance company.

Therefore, to facilitate the processing of your claim, we have adopted the following procedures:

- If you are eligible for orthodontic coverage, we will ask you for a copy of the insurance card and have you complete the following to provide us with the information we need to be able to file a claim on your behalf:

  Name of Insured: _____Patient's Name: _____

  Name of Insurance Company: _____

  Phone # of Insurance Company (Customer service or Benefit #): _____

  SS# or ID# of Insured: _____ Group #: _____

  Date of Birth of Insured: _____

  Relationship to patient: _____ Employer: _____

- We will provide you with an estimated benefit from your insurance company when treatment fees are quoted. Any benefits quoted are only estimates based on information given by the insurance company. **At any point during treatment if the insurance benefit is canceled or claims are denied for any reason, the Responsible Party will become responsible for the unpaid insurance benefit**. You are ultimately financially responsible to this office for all services rendered.
- We will complete the appropriate claim form and provide your insurance company with the following:
  1. Description of the malocclusion and proposed treatment
  2. Estimate of orthodontic treatment time
  3. Cost of treatment including retention and supervision, if applicable
- We will submit your claim to your insurance company in a timely manner.
- Please make your payments to this office as agreed upon under the terms of your financial contract. Some insurance companies will only pay to the insured. If your company is one of these, we will be happy to provide you with the orthodontic codes needed to file your insurance claim, but you will be responsible for filing and collecting all benefits.
- We only accept assignment of benefits from the **primary** insurance carrier. If you have **secondary insurance coverage** we will be happy to provide you with the orthodontic codes needed to file your insurance claim. But, you will be responsible for filing and collecting all benefits from the secondary insurance company.

I understand the above stated insurance policy. I authorize and request my insurance company to pay directly to "Orthodontics - Patrick P. Chen, DDS, PA" all my primary insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party / Insured: _____ Date: _____

For office use only:

INSURANCE VERIFICATION:

Date checked: _____ Spoke to: _____ Effective Date: _____

Orthodontic Coverage: _____ % Max: _____ Age Limit: _____

Orthodontic Deductible: _____ Payment Method: _____