Insurance Disclaimer

(Please read carefully)

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call your insurance and verify benefits, **it is not a guarantee of payment** by the insurance company and may vary according to your individual plan when the actual claim is submitted._____ (Initial)

Any treatment plan that our office proposes to you is an **estimate** of what your insurance coverage will be, it is not a guarantee. If you need the best determination of your benefits, then a pretreatment estimate is required. If you would like this to be done, you must specify to the treatment coordinator before any work is initiated. **(This takes 6-8 weeks or longer depending on your individual insurance plan).**_____ (Initial)

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. **The patient, not the dental office, is responsible** for knowing the dental benefits, frequencies and limitations according to the dental benefit guidelines. _____ (Initial)

Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a check. Also, remember dental insurance plans are not designed to cover all of your dental needs._____ (Initial)

I, _____, have chosen to allow Forever Smiles, P.A., to file my insurance and **I accept full responsibility** for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within 120 days of my date of service, then I will become responsible to pay at that time.

Patient's Name: _____ **Date:** _____

Parent/Guardian's Name: _____

Patient or Parent's Signature: _____

Staff Signature: _____