

IMPORTANT DENTAL INFORMATION FOR OUR PATIENTS

Understanding your insurance coverage can be quite challenging and our goal is to assist you in maximizing your benefits. We care for patients employed by many different companies. Each employer pays an insurance premium for specific coverage, which fits the company budget. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

OUR COURTESY SERVICE TO YOU INCLUDES

1. Researching your dental insurance plan to advise you of benefits available to you.
2. Filing your insurance within 48 hours of your visit and requesting payment to our office.
3. Electronically filing your insurance for short turn around.
4. Following the American Dental Association guidelines for coding procedures and filing insurance.

OUR EXPECTATIONS OF YOU AS THE OWNER OF YOUR INSURANCE POLICY

1. Payment of fees not covered by your insurance plan.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called usual and customary rates) and exclude some procedures based on prior conditions or length of time on plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 60 days.
5. Keeping our office informed of any changes in your insurance coverage or employment.
6. If inadequate information or enrollment problems arise, you will be responsible for the total fee at the date of service.

"I understand that if I default in a payment on this account and it has to be turned in for collection and/or legal action that I will be responsible for any and all fees involved in collecting the account."

I hereby authorize Ronald K. Greif, D.D.S. and Samir E. Ruvinov, D.D.S. to release to my insurance company, information acquired in the course of my dental treatment. I hereby authorize benefits to be paid directly to Dr. Ronald K. Greif and/or Dr. Samir E. Ruvinov. I understand that I am responsible for any unpaid balance.

Signature of Patient/Insured

Date