PEBBLE FAMILY DENTISTRY
ELAINE T. SHIM, D.D.S.

FINANCIAL AND DENTAL INSURANCE POLICY

We are committed to providing you with the best possible dental care. If you have dental insurance, we will gladly help you receive your maximum allowable benefits, thus minimizing your costs. In order to achieve these goals, we need your assistance and your understanding of our policy.

Payment for services is due at the time they are rendered unless payment arrangements have been made in advance in written form. We accept cash, check, Visa, MasterCard, Discover, and American Express. In order to keep our operating costs and ultimately your costs down, we generally do not bill patients. As a courtesy to you, we will file your insurance claim for you. In order to process your claim, we must have complete insurance information.

Returned checks will be charged a $25.00 fee upon notification to us by the bank, and we may require alternative means of future payments. You are responsible for all reasonable collection cost and attorney fees in the event of any default of balance owed.

When you make an appointment with us, please remember that this time has been reserved for you. A charge of $50.00 will be made for every half hour of your scheduled appointment time for broken or cancelled appointments without **24 hours** notice.

We will gladly discuss your proposed treatment and answer any questions relating to your account. We will not perform any procedure without your knowing the cost of the treatment up front.

As far as your insurance is concerned, please understand the following points:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are usually covered up to the allowance determined by each carrier. This does not apply to companies who reimburse based on an arbitrary "schedule of fees", which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We do not render our services on the basis that insurance companies will accept or pay all our fees. Proposed treatment plans are based on services needed.
4. Estimates of co-pays are based on information available at that time. Insurance carriers do not guarantee benefits until claim is processed.
5. If your insurance fails to pay the portion which they are supposed to cover, you are ultimately responsible for the balance due.

We must emphasize that as dental care providers, our relationship is with YOU, not your insurance company. While the filing of insurance is a courtesy that we extend to our patients, ALL charges are your responsibility from the date services are rendered. If questions or concerns arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Sincerely,

Pebble Family Dentistry

I HAVE READ THE ABOVE CONDITIONS AND AGREE TO THEIR CONTENT.

_____ _____

Patient Signature Date *Patient Name (Print)*

PAYMENT RESPONSIBLE PARTY INFORMATION

The following person is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Best time to call: _____

Address: _____
Street *Apt#*

_____
City *State* *Zip Code*

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street *City* *State* *Zip Code*

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last *First* *MI*

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____
Street *City* *State* *Zip Code*

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last *First* *MI*

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____
Street *City* *State* *Zip Code*

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

I hearby authorize and direct payment of the dental benefits otherwise payable to me, directly to Elaine T. Shim, DDS.

_____ _____
Subscriber Signature Date