Important Insurance Information

Understanding your insurance coverage and limitations can be quite challenging. Our goal is to assist you in maximizing your benefits. We accept and bill most insurance companies, but some policies will only cover you to be seen at certain offices. Each plan is slightly different in its covered services and fee schedules (the maximum amount they will pay for each service). We encourage you to become familiar with your policy exclusions, deductibles and required co-payments. Please bring your insurance card and photo ID with you to appointments.

Our courtesy service to you:

1. Submitting insurance claims within 24 hours of your visit; this includes attaching relevant clinical notes, x-rays and images to ensure maximum benefit payout.
2. Following the *American Dental Association* guidelines for coding procedures and filing insurance.
3. Treatment plans will include estimated insurance coverage of proposed treatment according to the information provided by your insurance policy. We will collect the estimated out-of-pocket portion at the time of service.

Our expectations of you, the owner of the policy :

1. Payment of fees not covered by your insurance plan.
2. Understand that the dental insurance policy belongs to you. We have no leverage to obtain payment from your insurance carrier.
3. Understand that dental insurance policies restrict payment for some services, use restricted fee schedules, and exclude some procedures based on prior conditions; as the provider, we are not provided access to all of these restrictions. These restrictions are based on the premium paid for insurance, not our fees or recommended treatment.
4. You are responsible for payment if the insurance company does not pay our office within 75 days.
5. You are responsible for informing us of any changes in your insurance coverage or employment.

I hereby authorize Dr. Neal W. Redman to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Neal W. Redman. I understand that I am responsible for any unpaid balance.

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Patient's Signature (or authorized guardian) Date