THE COLONY DENTIST FINANCIAL POLICY

I understand that I am financially responsible to The Colony Dentist for any charges not covered by my dental benefits. It is my responsibility to notify the organization of any changes in my dental coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim or predetermination. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Before any dental treatment has begun, the patient and/or responsible party will receive a consultation regarding treatment plan and cost. We require payment in full for the portion not covered by dental insurance. By signing below the patient agrees to an "Assignment of Benefits" to The Colony Dentist. In some instances, the assignment of benefits is sometimes mistakenly overlooked by insurance companies and mailed to patients; in that scenario the patient is responsible for signing the check over to the colony dentist, and the balance will be the patient's responsibility.

As a courtesy to our patients with insurance, we will file your insurance claim, allowing you to pay only your deductible and/or **estimated** co-payment as services are rendered. Please remember that the contract is between you and your insurance company. We make every effort to give you an accurate estimate of what your portion of the fees will be based on the information provided to us. However, we have no way to guarantee the actual terms of your policy. Any dispute coverage or the amount of reimbursement is between you and your insurance carrier. By agreeing to this policy you agree to all such conditions.

FINANCIAL POLICY FOR POSTERIOR DENTAL WORK

We only place natural tooth colored fillings, and natural tooth colored crowns. Most of our patients prefer composite, natural looking tooth colored fillings and crowns due to their aesthetic value. We will submit the proper code work performed within the fee guidelines allowed according to your insurance plan. Please keep in mind that any estimate according to the fee guidelines and that you are responsible for all fees in their entirety. **I understand that I will be billed for any difference in fees due to my insurance company changing codes to less valuable service. I am willing to pay these fees if they should occur.**

RELEASE OF INFORMATION TO SOMEONE OTHER THAN MYSELF

I authorize The Colony Dentist to release dental, appointment, and/or financial information over the telephone and/or to release copies of my dental records to the following person.

Name: _____ Relationship: _____

☐ **I have read, understood and agree to The Colony Dentist Financial Policy stated above.**

Last Name: _____ First Name: _____ Birthdate: _____

Signature: _____