

## Important Dental Insurance Information for our patients

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. Dental benefit plans are made available to employees or members and their families through companies, unions & associations; and may vary considerably from one plan to the next. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

*Our courtesy service to you includes:*

1. Filing your insurance within 24 hours of your visit & requesting payment of your benefit to our office.
2. Whenever necessary, a pre-treatment estimate form will be submitted to your insurance carrier prior to treatment to obtain an estimate of your insurance benefits.
3. Re-filing your insurance a second time within 60 days.
4. Following the American Dental Association guidelines for coding procedures and filing insurance.
5. Researching your dental insurance plan to advise you of benefits available to you.

*Our expectations of you as the owner of the policy:*

1. Completed and signed form at the first visit.
2. Keeping our office informed of any changes in your insurance coverage or employment.
3. Being aware of yearly maximum benefits and when they have been exhausted.
4. Payment of fees not covered by your insurance plan at the time the service is delivered.
5. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
6. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called usual & customary rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
7. Taking responsibility for payment if the insurance company does not pay our office within 75 days.

Thank you for your cooperation with your dental insurance coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

I hereby authorize Dr.Sadeghi 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.Sadeghi.  
I understand I am responsible for my unpaid balance.

\_\_\_\_\_  
signature of patient /Insured

\_\_\_\_\_  
Date