Financial / Insurance Policy

Please note: we accept most PPO plans. As well as limited Medicaid, prepay and discount plans

We DO NOT accept or participate with any DMO/HMO insurance plans

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an **estimate** of what your insurance coverage will be, it is not a guarantee. If you need **exact** payment of benefits, then a pretreatment is required. If you would like this done, you must specify to the office staff **before** any work is initiated. **(This takes 6-8 weeks).** _____ **(Initial)**

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay within **120 days** of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check. Also remember dental insurance plans are not designed to cover all of your dental needs.

Should your account be sent to collections, you will be required to pay your original balance, plus 40% of the balance due to cover collection and attorney fees. I hereby authorize the release of any medical information necessary to process claims and also authorize payment of benefits to Dr. Doakes or Dr. Kunstadter for services rendered. A copy of this authorization and assignment shall be considered as valid as the original.

I, _____, have chosen to allow The Smile Salon & Day Spa to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within **120 days** of my date of service then I will become responsible to pay at that time.

Print name: _____ **Date:** _____

Patient Signature: _____