

***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. We care for patients from many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

**OUR COURTESY SERVICES TO YOU INCLUDE:**

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Researching your dental insurance plan to advise you of benefits available to you
3. Re-filing your insurance a second time within 30 days
4. Following the American Dental Association guidelines for coding procedures and filing insurance

**OUR EXPECTATIONS OF YOU AS THE OWNER OF THE POLICY:**

1. Payment of fees not covered by your insurance plan for services rendered, at the time of the appointment. (an estimate will be provided)
2. Agreeing that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Understanding that dental insurance policies restrict payment for some services. Restricted fee schedules (called Usual and Customary Rates) 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.
4. Taking responsibility for payment if the insurance company does not pay our office within 60 days of service.
5. Keeping our office informed of any changes in your insurance coverage or employment.

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 your file.

***I hereby authorize Abcom Family Dental Care to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Abcom Family Dental Care. I understand I am responsible for any unpaid balance.***

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)