DR. JOHN L. CHIASSON DENTISTRY

INSURANCE DIRECT BILLING

PATIENT INFORMATION

DATE:

Patient's Name:_____ Date of Birth:___/_____/_____
first last initial day /month/ year

If Not Policy Holder Policy Holder's / Responsible Party's:

Name:_____ Phone # (____)_____
first last initial

Secondary Insurance Policy Holder's:

Name:_____ Phone # (____)_____
first last initial

Secondary Contact Name:_____ Phone # (____)_____

OFFICE PAYMENT POLICY DIRECT BILLING

Direct Billing is available under certain circumstances.

This office is pleased to offer you **DIRECT BILLING** as a courtesy, providing your insurance company permits. Our office agrees to file your claim forms to assist you in every way we can for reimbursement. However, it must be clearly understood that **"i**nsurance contracts" are between you, the patient / responsible party, and your insurance company or employer.

_____(Initial) **YOU ARE RESPONSIBLE FOR ANY AMOUNT NOT PAID BY YOUR INSURANCE COMPANY ON THE DAY OF TREATMENT** It is the responsibility of the patient / responsible party to be aware your coverage and benefits and are responsible for any fees not covered by your insurance company. By accepting your insurance on assignment, we are extending you CREDIT. This courtesy may be withdrawn at any time,with advance notice. All of the following are applicable:

_____(Initial) **CO-PAY PAYMENT DUE ON DAY OF TREATMENT**....**Co-pay, deductible payments and fees for non-covered services are due at the time of service**. If a submitted claim does not specify what the insurance company will pay the day of treatment the patient will be expected to pay the average percentage of what the insurance company has not paid on past treatments, or 20% of the current balance, for general procedures. For major treatments, such crowns, the patient is expected to pay the amount specified on a pre-determination letter, or 50% of the cost at the start of the treatment. It is important that we are given copies of pre-determination letters.

EXPLANATION OF BENEFITS....Your insurance company should provide an "Explanation of Benefits" to our office and the patient within 30 days of your office visit. If your insurance has not paid within 90 days, we reserve the right to request payment in full and you collect the funds from the insurance company.

DENIED CLAIMS....WE **DO NOT guarantee that the patient's insurance company will pay for services provided**, if a claim is denied the patient is expected to pay the balance immediately.

DISPUTES... Our office **WILL NOT** enter into a dispute with your insurance company over any claim. If you choose to discontinue your treatment plan or dismiss yourself from care against our advice you may be required by insurance company to pay for your care at your own expense .

CANCELLATIONS ...Your appointment time has been reserved especially for you. If you are unable to keep your appointment we require 2 full business days notice. **A charge may be applied for missed or cancelled appointments**, with advance notice. Repetitive cancellations and changes in appointments may result in patient release.

By signing below you agree that you understand and agree with all of the above policies, and accept the terms of assignment. I acknowledge that I am financially responsible for non-covered serviced, deductible, co-pay/insuranced and all fees resulting in and associated with the collection of any outstanding balance. I also understand that if I terminate my care and treatment, any fees for professional services rendered will be immediately due and paid.

_____ _____
Patient / Policy Holder Signature Date

_____ _____
Witness Signature Date