

YOUR DENTAL BENEFIT PROGRAM

Can assist you in obtaining and maintaining a superlative level of oral health!

Our office staff understands dental insurance and will be glad to assist you in obtaining the maximum benefits specified in your contract.

IT IS IMPORTANT THAT YOU REALIZE THAT.....

1. Your dental benefit program is a contract between you, your employer, and the insurance company. **We are not a party to that contract.** However, this office does file your insurance as a courtesy to you.
2. Our fees **generally, but not necessarily**, fall within the usual and customary fee structure determined by your carrier. Each insurance company updates their UCR (Usual and Customary Rate) fee schedule at 6-12 month intervals, based on the fees submitted for the previous 12 months. Therefore, the fee schedule is actually 18-24 months old. They then pay only those fees which are in the lower 40-80% of all fees submitted. How often they update their UCR and at what percentile they pay is determined by how much premium your employer is willing to pay. Ask our insurance coordinator to show you examples of the same fee submitted to three different insurance companies with three different UCR coverage levels.
3. **NOT ALL DENTAL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS.**
4. You (**not the insurance company**) are responsible to us for **all of our fees** for services rendered to you. Due to constantly changing insurance regulations, benefits, and deductibles we are only able to approximate your insurance balance. If your insurance company pays more than expected, you will be credited the difference. If your insurance company pays less than expected, you will be charged the difference. Final responsibility for payment rests with the person responsible for your account!
5. For patients who have insurance, an **ESTIMATE** will be given of the benefits that the insurance company is expected to pay. **Any portion not covered by insurance estimates is due at the time services are rendered.**

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care!

PATIENT SIGNATURE: _____ **DATE:** _____