Insurance

Please understand that as a dental care provider our relationship is with you and not with your insurance company. Filing of insurance claims is a courtesy that we extend to our patients but all charges are your responsibility from the date services are rendered. We have no leverage on assuring that your claims are paid. Our office is not responsible for collecting your insurance claim or for negotiating disputed claims. We invite you to bring your policy booklet with you and we will be happy to assist you in understanding your coverage.

Assignment Authorization / Release of Authorization / HIPAA

I, the undersigned, hereby authorize Pal Family Dentistry and/or its agents to apply for benefits on my behalf for services rendered to my dependents or me. I request payment from my insurance carrier be made directly to Pal Family Dentistry and in cases where the carrier had made payments directly to me, I will return funds to Pal Family Dentistry in a timely fashion. I also certify that the information on this form is correct and further authorize the release of any information for any claim to my insurance carrier. I agree that a copy of this signed release and of my records may be used in lieu of the original and authorize its release to all parties involved in my care and care of my dependents.

In addition, I agree that I have been offered access to Pal Family Dentistry's Notice of Privacy Practices (HIPAA) policies. Written copies are available at my request. I authorize Pal Family Dentistry to discuss my medical and/or dental information with the following people (list relationship):

Guarantee of Payment / Non-Covered Charges

I, the undersigned, understand and agree that I am financially responsible for all charges including those not covered by my dental insurance policy. Payment is due at the time services are rendered. I agree that it is a matter between me and my insurance carrier whether or not the insurance company pays Pal Family Dentistry all, a portion or none of the claim submitted on my behalf. I understand that if services are denied by my insurance carrier then it is my responsibility to pay for these charges. Regardless of my insurance situation, I understand that I am responsible for any balance due.

In the event that my account must be placed with an attorney or collection agency, I agree to pay attorney fees in the amount of thirty three and one third percent of the unpaid balance, any court costs and interest in the amount of eighteen percent per annum.

I further understand that I will be charged $50 for every scheduled appointment hour that I cancel or miss without giving 24 hours notice.

Signature of Patient or Responsible Party_____ Date _____
(parent or guardian if patient is a minor)

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