The Endodontic Group, Inc.

Dental Insurance Assignment Agreement

Welcome to our office! We consider it an honor to have been chosen for your endodontic treatment. We hope to make your visit with us as pleasant and comfortable as possible. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Insurance Assignment Agreement is indicative of our respect for your right to know prior to treatment, what our expectations are in the area of accepting your dental insurance. If you have any questions or concerns about this agreement, please do not hesitate to ask our business office staff prior to treatment.

Dental Insurance: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, and not your insurance company.
- We do participate in a few PPO plans, please ask our staff for further information. For patients with out-of-network dental insurance plans, we will gladly file for your insurance benefits as a courtesy to you, but will require payment of 50% of our fees at the time of service. Should your insurance company pay a dissimilar amount you will be notified of the difference.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one insurance company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Insurance companies will not guarantee benefits quoted over the telephone. Benefits are reviewed by your insurance company upon receipt of the claim. It is each individual patient's responsibility to have knowledge of their insurance benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.
- Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- After your dental insurance has paid its portion, a statement is sent to the mailing address on record, for any remaining balance. Payment is expected upon receipt of the statement.
- If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance due within two weeks.
- We do not file claims for medical insurance or more than one dental insurance company per patient.

Consent and authorization:

I authorize dental insurance assignment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office.
I have read and understood this document in its entirety, outlining office policies and financial policies of The Endodontic Group, Inc. Without any reservations, I agree to abide by the policies outlined herein.

Name (print) ______________________________________Signature______________________________

Date______________________

Minor Patients: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.
Form completed by: Name_____________________________Signature_____________________________
If patient is a minor, relationship to minor ____
Date______________Are you the person legally responsible for this child? Yes ______ No _______

Insurance Information:

Patient Name_______________________________Date of Birth_____________________________

Insured Name_______________________________Date of Birth_____________________________

Insured Social Security #____________________Employer________________________________

Insurance Company_________________________Group Number___________________________

Insurance phone number____________________

Claims mailing address____

Patient relationship to Insured: _____Self _____Spouse _____Dependent

BELOW FOR OFFICE USE ONLY:

Date_________________ Calendar or contract year _________________________________
Yearly Maximum Benefit_____________ Amount used this year______________________
Deductible amount_________ Deductible met? _________ Exam frequency _____________
Exam covered at ______________________ Last date of service________________________
Endo covered at _______________________Regular Endo frequency ___________________
Retreats covered? _____________________ Retreat frequency__________________________