COASTAL CONNECTICUT DENTISTRY

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INSURANCE POLICIES AGREEMENT

There are many complexities with dental insurance. Our financial policy requires payment in full at the time services are provided. We do accept assignment of benefits for most major insurance policies. **Please understand that your account must be kept current throughout treatment.**

If your plan provides benefits for services in our office, you will be asked to leave the anticipated co-pay at each visit. **THIS IS ONLY AN ESTIMATE.** We will file insurance claims and submit the information necessary for your insurance company to process those claims. This is a service we provide as a courtesy to our patients, but please understand you have the contract with the insurance company and ultimately are responsible for payment. If services are listed by your insurance company as "NON-COVERED BENEFITS", we will not be sending claims for those services and they will be your responsibility. This also applies when you have maximized your insurance and there are no benefits to claim. The insurance industry is a conglomeration of companies with many different policies. Those policies all have different insuring agreements, exclusions and conditions. **We will not guarantee a payment will be made from your insurance company**, nor will we make a settlement on a disputed claim. We will not disclose this information to any dental plan during an audit unless you agree in writing.

Our practice is committed to providing the best treatment possible to our patients. You are responsible for the cost of treatment provided regardless of an insurance company's arbitrary determination of the "allowable" fees. Once a claim is paid, the remaining balance is the responsibility of the guarantor, regardless of the estimate.

Remember, you are the holder of the contract. It is your responsibility to ensure you understand the contract between you and your insurance company and to know the benefits available under your policy. If after 60 days your insurance company has not rendered payment the balance will become your responsibility.

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PATIENT'S SIGNATURE (Parent if Minor) DATE

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PATIENT'S NAME (Please Print)

****Our team is available to assist you in understanding your benefits and filing the necessary dental insurance paperwork.****

www.CoastalCTDental.com
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