

TO OUR PATIENTS WHO HAVE MEDICAL INSURANCE

Our office is happy to assist families who are covered by medical insurance. Please read your policy to be sure that you are fully aware of any limitations of the benefits provided, including the claims filing deadline and if benefits are reduced if not pre-certified.

The fees we charge for services rendered are our usual and customary fees charged to all patients for similar services. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the type of coverage available. Also, some companies pay claims promptly while others delay payments many months.

Since we have no say in the selection of your insurance company, we have no control over coverage. Therefore we ask that you look upon your insurance realistically as a device that may or may not provide coverage. We are pleased to submit all the necessary information to help you obtain the reimbursement benefit you may be entitled to receive at the conclusion of treatment. We ask that at the end of treatment you request insurance be submitted at that time. We will only do this upon request as we have no way tracking who has insurance and when their treatment ends. We will always make the best use of your insurance as possible.

Our customary procedure in handling our patient's account is the same for all patients with or without insurance coverage. We are a fee for service office, meaning a total treatment fee is given and we will make payment arrangements for the entire fee before treatment begins. Monthly payment arrangements can be arranged for you by our office for those wishing to do so through an out of office source.

Please feel free to discuss with us any questions you may have regarding the processing of your claims.

Initial

_____ I understand this is a fee for service office.

_____ I understand my insurance may or may not cover services and it is my responsibility to understand my benefits.

_____ I understand it is my responsibility to request insurance to be submitted at the END of treatment.

SIGNATURE

DATE