## INSURANCE COVERAGE FOR YOUR TREATMENT

This office is happy to cooperate with individuals who are covered by insurance. We only ask that you read our policy to be sure that you are fully aware of any limitations of the benefits provided. Insurance is a contract between the patient and the insurance company for benefits. It is not a contract between our office and your insurance company.

The fees we charge for services rendered to those who are insured 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 types of coverage available. Some will have you pay a deductible of $50 or $100 and then anything over that amount they will cover at a percentage of the remainder of your bill, but not all of it. Also, some companies pay claims promptly and others delay payments many months.

Since we have no control in the selection of your insurance company (nor do we feel we should), we have no control over what they will pay or when they will pay for the services provided. Therefore, we ask that you look upon your insurance realistically as a device which helps you pay for your dental care. Please understand that assisting you with your insurance claim is done willingly but that regardless of the insurance coverage, the obligation of the bill for the services rendered is the patients'. Insurance claims not paid by the insurance company in thirty days are the entirely the responsibility of the patient. Please be assured that this office will always be happy to help you.

## RELEASE OF INSURANCE INFORMATION

I hereby authorize, Kevin Y. Myint, D.D.S., to furnish my insurance company all information which said company may request concerning my dental care.

I hereby assign to, Kevin Y. Myint, D.D.S., all sums payable to me from the amount of money of which I am entitled for dental and/or medical expenses, but not to exceed the charges for those services. I understand that I am financially responsible for those charges not paid by my insurance.

I agree that a photocopy of this, my original authorization, shall be considered equally authentic.

DATE_____ SIGNED (INSURED)_____

## MISSED OR BROKEN APPOINTMENTS

**A fee may be charged for appointments that are missed or broken without 24 hours notice.**

## FEE POLICY

All fees are due at the time of service completion. For your convenience, we can accept VISA and Mastercard. A finance charge of 1.5% per month is imposed on balances not paid within thirty days of receipt of billing statement. The annual percentage rate is 18%. In the event that these charges and fees are forwarded to an attorney or collection agency by the doctor, I agree and authorize additional payment of 30% of the highest collection balance for the treatment rendered as reasonable attorney's fees. If you have insurance, we will be glad to complete and submit your insurance forms and accept assignment of benefits. We will try to **estimate** your co-payment and your **estimated** co-payment is expected at the time of your visit. However, you are responsible for all fees not paid by your insurance. Since your eventual reimbursement is determined by your insurance carrier, we cannot be responsible for negotiating settlement on disputed claims. If this account becomes delinquent, you will be responsible for paying all costs associated with the collection procedure, including attorney's fees and court costs.

I have read and understand the above, and agree to the fees, insurance, and appointment policy.

DATE_____ SIGNED_____