

Dental Insurance Information

Name of person carrying primary dental insurance: _____

Birth Date: _____ Employed by (or Retired from): _____

Employer's Address: _____

Primary Insurance Company: _____ ID#/SS#: _____ Group #: _____

IF you have a second dental insurance policy, please fill out the following:

Name of person carrying Secondary insurance: _____

Birth Date: _____ Employed by (or Retired from): _____

Secondary Insurance Company: _____ ID#/SS#: _____ Group #: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services to said Doctor or his assignee at the time services are rendered or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me in writing within the time for payments thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if such be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date _____ Relationship to patient _____

Signature of guarantor of payment/responsible party Date _____ Relationship to patient _____

ONLY IF MONTH/YEAR IS CLOSED

If an insurance claim has been made which results in a zero payment **AND patient calls with new insurance information** and we need to re-submit:

- AND the month (or year) has already been closed
- First invalidate the procedure/s (service/s)
- Go to transactions (ADJUSTMENT) and write-off the amount/s of procedure/s
- Re-post the procedure/s into the ledger
- Re-submit the new claim, but first change date to reflect actual date of service

AUTHORIZATIONS

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
SIGNATURE ON FILE DATE

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
SIGNATURE ON FILE DATE

Wilbraham Family Dentistry, LLC
85 Post Office Park
Wilbraham, MA 01095