OFFICE POLICY FOR PATIENTS WITH DENTAL INSURANCE

You need to bring your insurance card, coverage booklet, and a completed and signed dental insurance claim form at your first visit, and at any time your insurance changes.

Please be aware that:

- **We will always do our best** to help you to maximize your benefits.
- **Although we file claims for you as a courtesy,** your dental insurance policy is a contract between you, your employer and your insurance company.
- **Your treatment plan is individually tailored,** and is not based on your dental insurance benefits or lack of benefits.
- **Not all services are a covered benefits in all contracts**. Some insurance companies arbitrarily select certain services they will not cover. *It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy*. Coverage issues can only be addressed by your employer or group plan administrator. *We cannot act as a mediator with the carrier or your employer.*
- **Our staff is trained to help you with questions you may have** relating to how your claim was filed , or regarding any additional information your carrier may need to process your claim. Please, ask if you have any questions.
- **As a courtesy to all of our insured patients,** we will file your dental insurance claim forms. You are responsible at the time of treatment for payment to us of any applicable deductible and for your coinsurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly. **Monthly accruing interest at the rate of 1.5% can be avoided if your personal financial responsibility is clear within 30 days of your treatment, thereby eliminating the need for statements to be generated and mailed to you.**
- **Your claim will be filed Immediately, and benefits are expected are to be paid within 30 days.** The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 45 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason. Any amounts expected to be paid by your insurance company, but not cleared by them within 45 days become your responsibility and, if not paid in a timely fashion, will begin to accumulate interest at the rate of 1.5% per month.

Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail.

***I understand and accept** the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction. **I agree** to pay for all treatment in a timely fashion as described so as to avoid any additional fees. I authorize Malki Dental to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Malki Dental to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.*

[For those patients with dental insurance who would prefer that their ins. co send payment to this office.] I hereby authorize my insurance benefits to be paid directly to Dr. Malki. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

*X*_____ _____ *X*_____

PATIENT (or legal guardian) ***DATE*** ***STAFF INITIALS***