Patient and Batesville Dentistry Financial and Assignment Of Insurance Benefits Agreement

Dear Patient,

Please **carefully read** the below information. This information outlines how we file your dental insurance and the payments due to Dr. Hodge by the patient. Please let us know if you have any questions regarding this information.

1. I authorize my insurance company to make payments to the dental provider.
2. This office is pleased to accept your insurance. We offer this service as a courtesy to our patients. However, the following must be clearly understood by the patient:
    a. The patient will pay the amount of the fee due that insurance will not cover at the time services are rendered by this office.
    b. If the insurance company elects to send payment to the patient, rather than the doctor**, payment is due in full** by the patient at the time the services are rendered.
    c. Insurance payments are usually received by the provider within 30 to 60 days. If a patient's insurance has **not** made payment to our office within 90 days, we will require that the patient pay the balance due. Once insurance makes their payment, the patient will be reimbursed the difference.
    d. We charge **21%** interest for any accounts that are **60 days or more past due**.

Initial _____

3. **Insurance Disclaimer**:
    a. Although we are willing to complete insurance information forms and submit a claim on behalf of the patient, we **do not** accept responsibility – under any circumstances – for the outcome of the transaction.
    b. Our office will **not** enter into a dispute with any insurance company over any claim. We will, however, cooperate fully with the regulations and requests of the insurance companies to ensure payment.
    c. Our office does **NOT** guarantee that the patient's insurance company will pay. Treatment plans printed by the computer are only an **estimate** of what your insurance company may pay towards your treatment.
    d. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason the patient's insurance claim is denied by the insurance company, the patient is then responsible for the **full amount of the bill**.
    e. It must be clearly understood by the patient that the insurance "contract" is between the patient and their insurance company**. The account is thereby the responsibility of the patient for any amount not paid by the insurance company.**

Initial _____

Payment Options Agreement

To reduce our administrative costs and keep our fees to you as low as possible, **we require that you pay for your portion of the fee at the time you receive treatment**. If you have dental insurance, the amount due at the time of treatment will be the amount we have estimated insurance will **NOT** pay. If you do not have dental insurance, the full fee will be due at the time treatment is provided.

Acknowledgement of Notice of Privacy Practices

**You May Refuse to Sign This Acknowledgement* (A copy of the HIPPA is available upon request)*

I _____ have been notified of this office's Notice of Privacy Practices.

_____ _____

Authorizing Signature Date