

**Important Dental Insurance Information for Our Patients**

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different employers with many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

**Our courtesy service to you includes:**

- 1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
- 2. Electronically filing your insurance for short turnaround.
- 3. Researching your dental insurance plan to advise you of benefits available to you.
- 4. Re-filing your insurance a second time within 30 days.
- 5. Following the American Dental Association Guidelines for filing insurance.

**Our expectations of you as the owner of the policy:**

- 1. Payment of fees not covered by your insurance plan at the time the service is rendered.
- 2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
- 3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance and not based on our fees.
- 4. Taking responsibility for payment if the insurance company does not pay our office within 30 days.
- 5. Keeping our office informed of any changes in your insurance coverage or employment

**I hereby authorize Dr. Dipika Shah to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Dipika Shah. I understand I am responsible for any unpaid balance.**

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Signature of patient/insured

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Date

**Pre Authorized Health Care Form**

I authorize Dr. Dipika Shah to keep my signature on file and charge my credit card account as listed below

----- Balance not paid by my insurance company

-----# of months----- x monthly amount \$-----

----- Full amount of each visit.

----- Signature of a card holder -----Date