ALASKA PREMIER DENTAL GROUP LLC

Insurance Policy

Importance of patient awareness regarding insurance benefits:

Alaska Premier Dental Group LLC realizes how important insurance benefits are. We ask that you carefully review your policy and/or contact your insurance carrier so you are aware of benefits, frequencies, limitations, and/or restrictions. Please be informed that dental insurance is a contract between you and your insurance company. Our role is to assist you with filing your claims. Your dentist is providing the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions. Please be aware that your insurance may have a yearly allowance (maximum) and anything over that amount will be your responsibility. If you have two insurance policies, please be aware of both policies – **not all secondary policies will cover remaining portions**. Your insurance mails a copy of an Explanation of Benefits (EOBs) to you. Please pay attention to these statements. Check your policy to see if have a dental deductible, and if your insurance pays at a percentage or by their allowed fee schedule. Please provide us with a copy of your insurance card and benefit booklet (if available) at your first visit or at the time of dental coverage changes. **It is your responsibility to provide us with any future changes in your insurance**. If any dental services have been provided with any other provider within the existing benefit year, please advise us.

_____(Initials) I understand the above information

Financial Policy

In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with estimates of fees. Patient, parent and/or guardian is responsible for the patient portion on the date of service and for any additional fees incurred in collecting a delinquent balance. This is not your insurance company's responsibility. **We will file all necessary claims to your insurance as a courtesy to you**. It is your responsibility to call your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility, and interest will be applied to your account up to the maximum allowable per month.

Financial options that we provide at this time:

Check those that apply for you:

☐ Cash or check on date of service
☐ 5% reduction on patient portion over 200.00 if paid **prior** to treatment with cash or check only
☐ Major credit card (American Express, Discover, MasterCard, Visa)
☐ Extended payment plan (based on credit approval)
☐ 5% Senior Citizen courtesy (age 65 and over)

It is your responsibility to complete treatment and follow recommended maintenance schedule. If the treatment and maintenance plans are not followed and/or appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment plan in a timely manner, further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints can be affected.

_____(Initials) I understand the above information

Appointment Commitment

We appreciate you choosing us to meet your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time.

Please review the following:

If circumstances occur and it is necessary to change your scheduled appointment, we request that you give us at least 24 hours notice. A broken appointment, one in which a patient does not call or show up, is not acceptable. If you have scheduled an appointment and do not show up or call, it may be necessary for you to come into the office personally and schedule any future appointments.

There may be a fee of 30.00 per missed appointment, per provider, per hour.

_____(Initials) I understand the above information

I understand and agree to the aforementioned, and I promise to pay any/all remaining balance on my account.

X_____Date_____

Signature of patient, parent or guardian