

## Dental Insurance and Credit Policy

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. Your employer pays an insurance premium for a specific range of dental benefits and benefit levels vary according to the plan chosen by your employer for preventative, basic and major services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

### Our courtesy service to you includes:

1. Filing insurance requesting payment of your benefits to our office.
2. Following the American Dental Association guidelines for coding procedures and filing insurance.
3. For those patients having double coverage, filing your claim with the secondary carrier for additional coverage upon receipt of payment from the primary insurance company.
4. Re-filing your insurance a second time within 60 days if necessary

### Our expectations of you:

1. Providing the information required to file an accurate claim on your behalf, including a copy of current insurance card.
2. Payment of fees not covered by your insurance plan on the date of service.
3. Realizing that dental insurance policies exclude payment for some services, sometimes use restricted fee schedules (Usual and Customary Rates), and deny procedures based on frequency limitations. All restrictions are based on your insurance policy and have no correlation to recommended treatment or fees.
4. Taking responsibility for payment if the insurance company does not pay within 60 days, a finance charge of 18% annually (1.5% per month) will begin accruing after 60 days from the date of service.
5. Keeping our office informed of changes in your insurance coverage.
6. In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by our office.

**I have read and understand Le'Centre Dentistry's dental insurance and credit policies with respect to payment on my account. I hereby authorize Dr. Le 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. Le, based on the requirements of my plan, and understand that I am responsible for any unpaid balance.**

\_\_\_\_\_  
Signature of Patient/Insured

Date: \_\_\_\_\_