FABRE FAMILY DENTAL CARE
INSURANCE AGREEMENT

Our office is happy to help you utilize your dental plan by filing your claims for you. All of our claims are filed electronically and are usually sent in the same day as your visit.

In order for us to be able to assist you in using your dental benefits, we will have to have the following information: a dental benefit card, a dental claim form, and a current benefit booklet. With out any one of these, we will not be able to assist you with your benefits, and you will be expected to pay for services as rendered.

Using the general breakdown of coverage from your benefit booklet, we can give you an estimate of how much your benefit plan will offset your cost at the time of your treatment with the understanding that you will be responsible for your portion at the time of service, and that you will pay any balance, in full, that is not paid by your benefit plan. Please keep in mind that these calculations are estimates of what your benefit plan will cover. When you pay your estimated patient portion, this does not mean that you have paid your final payment towards these services. If your insurance company does not pay the entire estimated insurance portion, **you are left responsible to pay the difference.** We do make every effort to get as close as possible to the covered amount, however, it is impossible to know exactly what your benefit plan will pay until payment is received.

We do not accept down graded fees or insurance code changes (any difference in fees will be your responsibility.

Please understand that we do not have any control over what is paid by your benefit plan. This is a contract between you and your plan provider. We will wait 60 days for your claim to be paid, then the balance must be paid in full by you. It will be your responsibility to call your benefit provider to inquire about claims, and any checks that we receive after you have paid your account will be refunded to you.

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I have read the above statement, and I agree that I will pay any co-payments and balances in full that are not paid by my benefit plan provider. I also agree that my benefit plan is a contract between me and my benefit provider and I will handle any problems that arise with my benefits. **By signing this form, I understand these terms.**

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Signature Date

ASSIGNMENTS OF BENEFITS

I authorize Fabre Family Dental Care to release any information relating to my claims. I understand that I am responsible for all cost of dental treatment. I also hereby authorize payment of the dental benefits otherwise payable to me directly to Fabre Family Dental Care.

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Signature Date

THANK YOU FOR YOUR COOPERATION!