

5010 Gunn Hwy
Tampa, FL 33624

(813) 960-5869

www.tampacosmeticdentist.com

(813) 968-7578 fax

INSURANCE

Assignment of benefits may be accepted only after your insurance has been verified and eligibility requirements have been met. We accept assignment of benefits as a courtesy to you. However, insurance payments are an ESTIMATE based on information obtained from your carrier. There is no guarantee of payment or that they will pay the exact amount estimated. Your estimated co-pay is due at the time of service. Any unpaid balances by the insurance company remain your responsibility. In the event that we are unable to collect on any outstanding insurance claims within 90 days, the balance in full will be billed to you and payment is expected. We require a credit card number and photo ID to be kept on file as a guarantee of payment in the event the insurance company does not pay the balance in full. We will contact you prior to charging your credit card. If you do not have a credit card number we will not be able to accept assignment of benefits. Payment in full is expected in cases where insurance companies will not assign benefits to us but are known to send reimbursements checks directly to the insured. Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. Please be aware that some, and perhaps all, of the service provided may be non-covered and not considered reasonable and necessary under various insurance plans. Our practice is committed to providing the best treatment for our patients and we charge a fair fee for the high quality of dentistry that we provided. You are responsible for payment regardless of any insurance company's arbitrary determinations of "usual and customary" fees or need for treatment.

I have read, understand and agree to this Financial Policy. I have been given the opportunity to discuss questions or concerns with a member of the staff.

Signature of Responsible Party _____
Date _____

CREDIT CARD AUTHORIZATION (for patients with insurance):

I hereby authorize payment by credit card for any unpaid balances on my account exceeding 90 days.

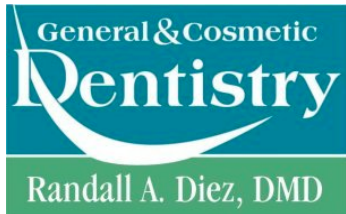
Type of Credit Card _____

Credit Card _____

3-digit Number _____

Expiration Date _____

Name (print) _____



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