INSURANCE INFORMATION

Patient's Name:

First Last

Address: _____

_____

☐ I have dental insurance and request that Virginia Dental Solutions file my claims for me.
☐ I have both primary and secondary insurance plans.
☐ I have dental insurance but wish to file my own claims.
☐ I have no dental insurance-Read & Sign Reverse

Primary Insurance Information

Name of Insured: _____
Insured Social Security #: _____
Insured Identification #: _____
Insured Date of Birth: _____
Effective Date of Policy: _____

Employer: _____
Insurance Company: _____
Group #_____

Group Coverage? ☐ Single Coverage? ☐

Relationship of patient to the insured: ☐ Self ☐ Spouse ☐ Child _____ Other(Please Specify)

Mail claims to: _____

_____

Secondary Insurance Information

Name of Insured: _____
Insured Social Security #: _____
Insured Identification #: _____
Insured Date of Birth: _____
Effective Date of Policy: _____

Employer: _____
Insurance Company: _____
Group #_____

Group Coverage? ☐ Single Coverage? ☐

Relationship of patient to the insured: ☐ Self ☐ Spouse ☐ Child _____ Other(Please Specify)

Mail claims to: _____

_____

Many insurance companies have stopped using social security numbers and are using a subscriber number instead. If your insurance still uses your social security number we MUST have the complete nine digit number, not the protective X's printed on your card.

Insurance filing is a courtesy provided to the patients and is in no way a responsibility of the office. We must have the correct information as well as your signature on file at the time of service. If not, you will need to file your own claims.

I hereby authorize payment of benefits directly to Virginia Dental Solutions. I understand that I am responsible for charges not covered by my carrier. A photocopy of this authorization shall be considered as valid as the original.

_____ _____

Patient or Parent/Legal Guardian Signature Date

Office Financial Policies

Estimated Co-Payments

If we file to your insurance as a courtesy, we do require you to pay your ***estimated*** co-payment at the time services are rendered. Please understand that the co-payment is an estimate and final financial responsibility is determined once the insurance payment has been posted to your account. If there is an overpayment, we will be certain to refund those monies to you; likewise, in the event that the co-payment was underestimated, a statement will be sent for any balance remaining.

Dental Insurance

Dental insurance is designed to assist you with dental expenses, but in general is much more limited than medical insurance plans. Your insurance coverage is determined by what your employer has purchased. Payments for services can vary widely from policy to policy. Some procedures may be denied based on age, pre-existing conditions or length of time on the plan. These restrictions are based on your specific plan as determined by your employer's contract with the insurance company. Please bear in mind that our relationship is with you and not with your insurance carrier. We have no leverage or influence on benefit determination, covered procedures or payments. If you are unsure about your insurance coverage, we advise you to contact your dental insurance carrier for information and clarification about your benefits.

If you have insurance through your employer, and you are the policy holder, (the insurance is in your name) this insurance will be primary for you, and your spouse's insurance policy will be secondary. The insurance policy thru your spouse's employer would be their primary and your policy would be their secondary.

UCR's (usual and customary rates) are applicable only to plans with which we currently participate. Please note that plan participation is always subject to change. Please ask if you have any questions regarding plan participation.

Payment Options:

Cash, Personal Check, Visa, Mastercard, American Express and Discover. In addition, we can direct you to a patient financing program which offers a variety of payment plans tailored to your specific needs.

Delinquent Accounts

Interest and attorney fees may accrue if your account is not kept in good standing. Details are listed in the subsequent financial agreement below.

Returned Checks

A fee in the amount of $35.00 will be charged for all returned and "insufficient fund" checks.

Broken and Cancelled Appointments

We reserve appointment times specifically for you and as a courtesy, we attempt to remind you of your appointment by calling you 2 days prior to confirm the scheduled date, time and location. If we cannot speak to you directly, we will try to leave a message for you. However, if our efforts are unsuccessful, we still expect you to be responsible for the appointments that you have made. We do require 24 hours notice in the event that you must cancel or reschedule and do reserve the right to charge $100 per hour of scheduled time for appointments that are broken or cancelled without sufficient notice.

By signing below, I certify that I have read the financial policies (stated above) and understand these policies. I agree to abide by the policies above for treatment provided by the practice of Drs. Novick, Hartz, Hall, Novick, Sharma, Martinez and their associates. I certify that all information provided is correct. I hereby authorize the doctors and staff to release personal information to the insurance company for all persons on my account.

FINANCIAL AGREEMENT: I understand and agree that the payment of my bill is my obligation, regardless of how much my insurance covers. All filings of insurance papers, confirmation of insurance coverage, and/or payments are my responsibility. We will do our utmost to help you understand your insurance benefits and file your claims for you; however any assistance in these matters provided by the doctor and/or staff is strictly a courtesy and implies no responsibility on their part for filing, follow-through, or confirmation of coverage. The undersigned is aware that a charge of $100/hour of scheduled time may be made for broken appointments or those cancelled in less than 24 hours. In the event that this account should become delinquent and is placed in the hands of an attorney for collection, I agree to pay the balance due, and interest at the rate of 1.5% per month (18% per annum), beginning 30 days after the monies were due or expenses were incurred, all court costs, and attorney fees of 33-1/3% of the principal and interest owing. I further agree to pay returned check charges of $35.00 per returned check. I understand and agree that this agreement is reaffirmed each time either I and/or any member of my family receives services.

_____ _____ _____

Signature of Responsible Party Print Name Date

VIRGINIA DENTAL SOLUTIONS
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