To our uninsured patients:

Payment in full is expected at the time of service unless written financial arrangements have been made with the office.

To our insured patients:

Each employer's plan is slightly different in its covered services. Your dental insurance plan is designed to share in the cost of your treatment and will most often not cover the entire cost. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

- Filing your insurance claim within 48 hours of your visit and requesting payment of your benefit to our office.
- Electronically filing your insurance for short turn around (if your insurance allows).
- Re-filing your claim a second time within 30 days if necessary
- Helping you receive the maximum dental benefits available under your policy
- Allowing payments with all major credit cards (Visa, MasterCard, AmEx & Discover).

Our expectations of you include:

- Payment of fees not covered by your insurance plan at the time service is rendered.
- Providing our office with accurate insurance and employment information.
- Understanding that your insurance policy belongs to you and that we have no leverage to obtain payment from your insurance carrier.
- Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR or usual customary rates) and exclude some procedures based on prior conditions or length of time on the plan (waiting period). All restrictions are based on the premium paid for the insurance, not our fees or recommended treatment.
- Taking responsibility for payment of all fees if the insurance company does not pay our office after 30 days

Dental Insurance Authorization and Release of Information

I hereby authorize payment of my insurance benefits to the office of Dentistry of The Pines. I understand that I am responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to 3rd party payers and/or other health professionals.

X____
Insured or Responsible Party Signature

X____
Date

Method of Payment (Please check)

Cash_____ Check_____ Credit Card_______ Insurance_______ Care Credit_______ Lending Club_______

Consent

If the patient is a minor, it is necessary that a signed permission be obtained from a parent or legal guardian before any dental services are rendered. I authorize the staff of Dr. Jason Graves & Associates, PA to provide dental treatment and I will be responsible for the cost of the dental care. I understand that I am financially responsible for all treatment fees, including any amounts not paid by my insurance company within 30 days following treatment. I understand that there is a 1 ½% monthly finance charge applied to account balances that are more than 60 days past due. Should it be necessary to refer my account to an attorney or agency for collection, I agree to pay all attorney, court and collection fees.

X____
Signature of Patient/Parent/Guardian

X____
Date