**R. L. Daschbach & Associates**

**Office Financial Policy Agreement**

**These insurance companies below are IN-NETWORK** at our office. We will submit the claims for you. You are responsible for your ***estimated*** portion at the time of service. We will bill you for any balance after the insurance payment is received. You may have a balance due beyond your estimated payment.

Please indicate which IN-NETWORK insurance you will be using:

Sunlife Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Blue Cross/Blue Shield GRID+ Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Anthem GRID+ Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Cigna PPO Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Delta Dental Premier/PPO Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

United HealthCare PPO Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Lincoln Financial Group Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Guardian DentalGuard Preferred Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

**These other insurance companies are OUT-OF-NETWORK.**

If your dental insurance provider is **OUT-OF-NETWORK**, we will gladly submit your claim. However, out of network fees **will** apply. An estimated fee will be calculated and **due the day of service.** *Please keep in mind: Insurance companies that are out of network may say they will pay 80% of allowable fee. This means they will pay 80% of THEIR allowable fee, not 80% of our fee.*

Aetna Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

AmeriHealth Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Cigna PPO Advantage Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Guardian Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Everence Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Humana Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Metlife Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Principal Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Pro Benefits Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

Populytics Yes\_\_\_ No\_\_\_ initials \_\_\_\_\_

**We want to emphasize that as dental care providers, our relationship is with you as our patient, and not with your insurance company or employer. Although we will file dental claims with your insurance company, all unpaid charges are ultimately the patient’s responsibility.**

* In consideration of the services provided to me by the office, I agree to pay in full my estimated portion at the time of service. I also agree that I shall be responsible if a balance remains once insurance has paid and will pay it in a timely manner.
* I grant permission to you and the staff to telephone me at any time to discuss matters related in this form (this includes my immediate family who are under my insurance)
* I have read and fully understand the conditions of treatment.

***I read and understand the office financial and cancellation policy.***

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Patient Name If minor, printed name of responsible party

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Signature of responsible party Date