



Dental Insurance & Financial Agreement

We offer our new and existing patients flexibility in paying for dental treatment with the following options. Please take a minute to review them, and decide which option works BEST for you.

OPTION 1: NON-ASSIGNMENT

This is the most popular option and by far the easiest! You will be in control of your insurance benefits, by paying in full for treatment at each appointment, and being reimbursed directly by your insurance company. This allows you to keep personal records of all dental transactions, insurance reimbursements and track how close you are to using your benefit maximum. Insurance companies reimburse patients within 1 – 4 business days.

I agree with the policies outlined in Option 1 and will sign below.

Signature of Patient or Responsible Party: _____ Date: _____

Print Patient Name: _____

OPTION 2: ASSIGNMENT

Kay Dental Care to accept assignment (payment) of benefits from your insurance Carrier. It does not allow your insurance company to release any other information to us, due to the Health Privacy Act. We want to make you aware that we may experience some difficulty in communicating with your insurance company, and ask for your cooperation, understanding, and patience.

1. We bill directly to your insurance company and collect the co-payment at the end of each visit. If you are covered at 100% - no co payment will be collected unless there is a balance for other circumstances. I.e. not being covered for a service or maximum being reached.
2. This option requires you to have a valid credit card number on file.
3. If we still have not received your insurance payment within 30 days after services are rendered, then we will process a payment on your credit card after notifying you. At that time, you may have an option to change your method of payment to set your outstanding account balance to a "zero balance"

We suggest you contact us 30 days after your visit in order to find out the status of your account and immediately call your insurance provider to enquire on the status of your claim. We will assist you in any way we can receive reimbursement from your insurance company.

I agree with the policies outlined in Option 2 and will sign below authorizing Kay Dental Care to process a payment to set my outstanding account balance to "Zero" by using the given credit card I have provided for any dental claim not paid by my insurance company within 30 days. A receipt for this transaction will be mailed with a paid statement.

I authorize Kay Dental Care to keep my signature on file to issue any credit/debit memos, as well as outstanding payments for 30 days of my last visit to my Credit Card Account. I agree that it is my responsibility to follow up on my account status after 30 days of my visit. I agree to keep Kay Dental Care updated with my current credit card. This credit card information will be kept on a separate confidential file that is secure.

Credit Card Number: _____ Exp: _____ CVS: _____

Signature of Patient or Responsible Party: _____ Date: _____

***** FOR THOSE WHO HAVE SECONDARY INSURANCE – YOU WILL BE RESPONSIBLE TO PAY YOUR CO-PAYMENT REGARDLESS OF EITHER OPTION ABOVE – WE WILL SUBMIT ON YOUR BEHALF FOR YOUR REIMBURSEMENT*****