



EVERGREEN DENTAL ASSOCIATES, LLC

281 Western Avenue • Augusta • Maine • 04330 • (207) 622-0861

IMPORTANT DENTAL INSURANCE INFORMATION FOR OUR PATIENTS

Understanding insurance coverage can be quite challenging. Please note that we always encourage you to check with your insurance company prior to any treatment completed, as the total investment given at the time the appointments are being scheduled are just *estimates*. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in its coverage services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments as well as to whether or not you may have a waiting period. At any time you may pay your entire portion at time of service and be reimbursed by your insurance company.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance claim for a short turn around.
3. Estimating as closely as possible your benefits available to you.
4. Re-filing your insurance a second time within 60 days.
5. Following the American Dental Associations guidelines for coding procedures and filing insurance.
6. Providing all paperwork necessary in the event your insurance does not participate with us.

Our expectations of you as the owner of the policy:

1. Estimated payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance *not our fees or recommended treatment*.
4. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
5. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign below to acknowledge your understanding of our policy and please have your insurance card ready for us to duplicate for your patient record.

I hereby authorize Bruce Kilgour, D.M.D., Peter R. Shumway, D.M.D., Garth M. Duff, D.M.D. and Heather S. Harper, D.D.S. to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Bruce Kilgour, D.M.D., Peter R. Shumway, D.M.D., Garth M. Duff, D.M.D. and Heather S. Harper, D.D.S. I understand I am responsible for any unpaid balances. For those with no insurance, I acknowledge that payment in full is expected of me at the time service is rendered.

PATIENT/GUARDIANS SIGNATURE

DATE