GREGORICH & MATACK
FAMILY DENTAL

Insurance Information and Financial Agreement

Patient Last Name:_____ **Patient First Name:**_____ **DOB:**_____

FINANCIALLY RESPONSIBLE PARTY INFORMATION-Information of who holds the insurance coverage

Last Name:_____First Name:_____

Date of Birth:_____ Social Security Number:_____

Address:_____

City:_____State:_____Zip code:_____

Primary Phone:_____ Email:_____

Employer:_____Occupation:_____

Relationship to Patient:_____

***** Do you have current dental coverage?** Yes ☐ No ☐

***** Please indicate who holds insurance coverage for the patient? (Self, spouse, parent, guardian etc…)**_____

***** Do you have dental coverage with more than one insurance plan?** Yes ☐ No ☐

********Please provide us with your dental insurance card(s)* **as we need to verify with your company that the policy is active and entered correctly to ensure accurate claim submission, insurance payment and assisting in pre-estimates. (If you indicated you *DO* have more than one insurance coverage plan, please provide us with *all active insurance cards*.)**

*****If you are self pay, we may ask your to set up a payment plan for services if you are unable to pay on day of service. We want to ensure the patient receives the care they need, as well as determining a reasonable financial plan that is agreed on by both parties (you as the financially responsible and our office). We are here to work with you!**

By signing this consent, you understand that we are billing the insurance company you provided above and you are financially responsible for any treatment not covered by your insurance for you or minor children you are responsible for.

We will also assist you by contacting your insurance company at your request for a treatment estimate. We would be providing them with your treatment plan, visit notes and x-rays needed to process request. However; please understand this is not a guarantee that your insurance will pay exactly what estimated at the time of their response. Due to the many variables to specific coverage, we encourage you to contact your insurance company for a details pertaining to your benefits allowing them to provide you with the most accurate information as your insurance provider.

Consent signed by:_____ (Please print clearly)

Relationship to patient :_____

Signature:_____ Date:_____

I UNDERSTAND WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED. I AUTHORIZE RELEASE OF INFORMATION OF ANY DENTAL TREATMENT TO MY INSURANCE CARRIER. I ALSO AUTHORIZE PAYMENT DIRECTLY TO THIS OFFICE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. We require 24 hour notice for cancelations. In the event you No Call/No show to an appointment, your account will be billed a $60.00 fee. Two No Call/No Shows will include a $60.00 fee as well as any further scheduling to be limited to same day appointments. Third No Call/No Show appointment for a patient will result in the inability to schedule with our office moving forward.