INSURANCE EXPRESS CHECK OUT FORM

Patient Name: _____Date: _____

With the introduction of the new Health Privacy Act and the diversity of dental benefit packages, more and more dentists are not accepting insurance as payment. It is difficult to maintain accounts with a zero balance because of difficulty in estimating what your insurance payments will be. It has been time consuming and difficult for us to continually collect or refund balances remaining, after insurance payments are received. We would rather invest our time ensuring that optimal dental care is given. We would like to be able to continue to offer our new and existing patients flexibility in paying for dental treatment with the following options.

OPTION 1 - Fee for Service

This option allows you to be in control of your insurance benefits, by paying in full at each appointment for treatment and being reimbursed directly by your insurance company. This will enable you to keep personal records of all dental transactions, all insurance reimbursements, track maximum allowable benefits and you will be more aware of what your plan does and does not cover. You will not have to worry about having outstanding account balances with us and you will not have to come in to collect monies that we may owe to you. When insurance companies are reimbursing patients, payment usually takes one to two weeks to be received, especially if your plan accepts electronic dental claims. If required, we will send electronic claims for you at each appointment.

OPTION 2 - VIP Express Checkout

Our VIP Express Checkout Program allows us to continue to offer you the convenience of using your insurance plan as a form of direct payment. Please complete the information below. It will be kept confidential and used only under the agreed terms.

- Insurance Company Name _____Plan# _____ ID# _____
  Subscriber Name_____DOB_____
- 2nd Insurance Plan _____Plan# _____ ID#_____
  Subscriber Name_____DOB_____
- 3rd Insurance Plan _____Plan# _____ ID# _____
  Subscriber Name_____DOB_____

PATIENT AGREEMENT

I agree to the FINANCIAL RESPONSIBILITY for the following: **Account balance**

I _____ authorize Sherwood Dental to keep my signature on file and to issue a charge to my credit card account for my account balance once my insurance portion has been collected. I will be notified by phone or mail if any charge is in excess of $500.00. I give my permission for any claim not paid by my insurance company within 90 days, to be automatically put through on my credit card. A receipt for this transaction will be mailed with an account statement.

Payment by: · Visa · MasterCard

Credit Card Number:_____ Expiry Date:_____

Name on the card:_____

Signature:_____

I do not have a credit card, but I have permission for Sherwood Dental to use a family member or spouse's card.
Relationship to this person: _____ Their phone # _____
Credit Card information provided above.