

Payment and Insurance Information

Methods of Payment

1. Cash, Check, Credit/Debit Card, or Care Credit

Dental Insurance

1. We are both PPO and Premier Delta Dental Providers
2. We are In Network Providers for Municipal Health, BCBS, MetLife, Cigna and GEHA.
3. We accept Delta Dental Smiles for Kids, and MCNA for children only (up to and not exceeding 21 years old)
4. Our office will assist you in obtaining your insurance benefits specified in your contract. However, your insurance is a contract between you, your employer, and your insurance company. We will need a copy of your insurance card with the name, address and telephone number of the insurance company. Without this information, we will be unable to file your insurance and we will ask that you pay for all your charges.
5. As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the insurance payment of authorization at the end of this form. We do require that your estimated co-payment and deductible be paid at the time of service.
6. Please remember that insurance is considered a method of reimbursement.
7. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Related Information

1. Payment is due at the time services are rendered.
2. We welcome open discussion of services and fees prior to treatment in order to avoid any misunderstandings.
3. In the event that an account is not paid within 90 days, we will refer the account to an outside collection source. You will be responsible for all fees incurred for the collection of your account, not limited to attorney fees, court costs, or collection agency fees. Furthermore, it is the patient's responsibility to keep the practice up to date on contact information including address changes.
4. Returned checks will be sent to the Prosecuting Attorney's office for collection. There is a charge of \$25.00 for insufficient funds.
5. The parent/guardian that brings the child to the appointment will be held responsible for all costs associated with the dental treatment performed. The office is unable to bill or collect from a third party while you try to collect.
6. If the patient is being seen for an emergency or accident, you will be held responsible for all costs associated with the service. We will provide you with a form that you may submit to your insurance company for them to reimburse you.
7. Your appointment time has been reserved for you, any changes in your appointment time can affect other patients. As a courtesy to us and other patients 24 hour notice is required to avoid a \$25.00 charge.
8. We ask that you inform us of any changes in information such as address, phone numbers, or insurance information. We will ask you to update this information periodically regardless of any changes.

I have read and understand the above information. I understand I am responsible (regardless of insurance) for any charges incurred from services rendered.

NAME (PLEASE PRINT) _____

SIGNATURE: _____ DATE: _____

Insurance Assignment of Benefits: I hereby authorize payment of dental benefits to be sent to Thomas M. Holman, DDS, P.A.

SIGNATURE _____