DENTAL IMPLANT SOLUTIONZ

INSURANCE GUARANTEE OF PAYMENT

Patient Name:_____ **Date:**_____

INSURANCE AND PATIENT PORTIONS ARE ESTIMATES ONLY and is provided only as a courtesy, NOT A GUARANTEE OF PAYMENT.

_____I hereby authorize the release of information to my insurance company. I authorize if necessary, the dentist/office to request a review of, and or pursue an appeal with my insurance company claim determination.

_____I understand that my insurance company does not cover cosmetic procedures or procedures covered by alternate treatment benefits (i.e. Partials vs. bridges, amalgam vs. composites (white) fillings, etc). Additional surgical parts, lab upgrades and/or utilization of the laser in the form of troughing may apply pending treatment starting at $100-$200 per unit, pending complexity of case.

_____In the event that your insurance carrier does not pay for treatment or pays less than the estimated amount, you agree and understand that you are responsible for the unpaid balance. It is your responsibility to know and understand any limitations with your coverage offered by your carrier/employer.

_____After 45 days from filing your Insurance claim and NO payment has been received, YOU WILL BE RESPONSIBLE for those charges assessed to your account.

_____Insurance companies DO NOT guarantee payment on either written or verbal verification. That is why we require a credit card number to be on file with our office. **Please be assured that the front desk will info you before your credit card is processed for your payment on any outstanding balance.**

If you do not understand this policy or need to ask a question regarding this matter please feel free to speak with our Insurance Coordinator before any treatment is completed

I hereby authorize Dental Implant Solutionz to charge my credit card with my verbal and written consent. By signing, I agree that charges cannot be disputed and that I am fully aware of the terms and conditions stated above. **I ASSUME ALL RESPONSIBILITY FOR PAYMENT.**

Name on Account/Cardholder:		Email:
Account Type: ____Visa ____MasterCard ____Amex ____Discover		
Card Number:	Expiration:	Security Code:
Street Address:		
Signature:		Date:

IF YOU DO NOT WISH TO HAVE YOUR CREDIT CARD NUMBER ON FILE, YOU WILL THEN BE REQUIRED TO PAY IN FULL AT TIME OF SERVICES ARE RENDERED AND YOUR INSURANCE COMPANY WILL REIMBURE YOU DIRECTLY.