Sierra Smiles

Family & Cosmetic Dentistry

Insurance Policy

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to assist you in maximizing your benefits. We care for patients from many different employers. Each company pays an insurance premium for specific coverage which fits the employer's budget. Each plan is different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance electronically (when available) within 24 hours of service requesting payment be sent directly to Sierra Smiles.
2. Following all American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. You are responsible for payment of fees not covered by your insurance.
2. Please understand that the insurance policy belongs to **you** and we have no leverage to obtain payment from your insurance carrier. The insurance contract is between yourself, the carrier and sometimes your employer.
3. Realize that dental insurance policies restrict payment for some services. They also use restricted fee schedules (UCR) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, not our fees or recommend treatment.
4. You will need to take responsibility for any fees your insurance has not covered after 60 days. At this time you will be contacted to pay the balance on the account. This balance is subject to a 1.5% monthly finance charge for the outstanding balance. Any expenses incurred in collecting a past due account will be added to the balance.

By signing this form all policies are understood and agreed to.

Patient or Guardian:

_____ _____

Signature Date

Insurance Authorization Statement

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature_____ Date_____