Parkside Dental

The financial obligation for dental treatment is between you and our office, regardless of insurance coverage.

Because your dental benefits are governed by a contract between you/your employer and your insurance company, if we have not received payment from your insurance carrier 30 days after the claim is filed, the remaining balance will be due and payable by you.

The treatment we recommend is determined by what is best for your dental health. Our recommendations are based on your dental needs, not your insurance coverage. Your insurance company may or may not cover all recommended procedures. We request that you understand your benefit plan and be familiar with the dental benefits covered by your insurance in advance of your appointment so that together we can make the best treatment decisions. If you have any questions about your coverage, we encourage you to call your insurance company's Customer Service Center to learn more about your coverage.

Please remember that dental insurance is not designed to cover 100% of the cost of all treatment. For example, you may choose treatment that your dental insurance excludes from coverage (i.e., a "non-covered service"). In those cases, you will be responsible for the full amount of those services. Our staff is happy to provide you with estimates for the treatment options you have chosen, and answer any special concerns or questions that you may have.

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations or other entities as deemed necessary by this office. I authorize the use of this signature for all insurance submissions.

I authorize this office to charge my credit card or bank account for any unpaid balances, including but not limited to balances after insurance payment. I understand in certain circumstances, my credit report maybe requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand check payments may be converted to automatic bank drafts. I have received a copy of the Notices of Privacy Practices form.

I have read and understand all the information contained on this form. I understand and agree that I am responsible for the balance on my account for any professional services rendered, without regard to whether I have insurance.

Patient Name (Please Print):_____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

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