Dr. N. Primiano & Dr. D. Mach
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Naperville, IL 60540
630-357-9850

INSURANCE ASSIGNMENT POLICY STATEMENT

Dear Patient:

You have selected "INSURANCE ASSIGNMENT" as the method of choice to take care of your financial obligation with this office.

It is important that you realize that in this office we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and as such, our patients must understand and agree to the following:

1. That you are considered a cash patient until you bring in complete insurance documents and this office qualifies and accepts your coverage. Complete documents entail:
    a. A current DENTAL insurance card showing the policyholder's name, social security number, group number, carrier telephone number and claim address. OR, in the event your carrier does not provide cards;
    b. A completed dental claim form (which can be obtained through your Human Resources Department) containing your carrier's phone number, claim address, and group number.
2. That you are ultimately responsible for full payment of any and all services rendered. This office makes estimates based on a co-payment percentage provided by your insurance carrier. The estimate is not a guarantee of payment by your insurance carrier. If for any reason your insurance carrier does not cover your treatment, you will be responsible for full payment.
3. That you must pay all deductibles in full at the first visit of your insurance carrier's fiscal calendar in which the deductible applies.
4. That co-insurance (the estimated patient portion of the treatment based on the co-payment percentages provided by your insurance carrier) must be paid at the time services are rendered.
5. That if your carrier has not paid a claim within 60 days of submission, you are responsible for taking an active part in the recovery of your claim and that after 90 days, you will be responsible for payment in full of any outstanding balances including any finance charges that may have occurred.
6. That in the event that you discontinue your program of care prior to the doctor's consent, you are responsible for payment in full of any outstanding balance and the courtesy of insurance assignment is immediately discontinued.
7. It is your responsibility to track your insurance usage. Upon request, we can determine the amount of insurance payments received by this office, but you are ultimately responsible for understanding your plan limitations and frequency's (e.g. x-rays, cleanings, age limits, etc.) and any payments not made by your insurance carrier in the event your annual maximum is met.

This insurance assignment policy must be followed and we ask that you sign this form as acknowledgement that our policy was explained to you, that you understand it, and that you accept full responsibility. If you opt not to sign this policy, full payment for your treatment will be due at the time of service and our office will, upon request, supply you with the necessary paperwork to file with your carrier.

Date: _____

Patient's Name: _____

Patient's Signature: _____

Address: _____

City, State, Zip: _____

Witness Signature: _____