Island Grove Dental
Insurance Acknowledgement

One of our goals is to assist you in maximizing your dental insurance benefits. As a courtesy to you, we will file the claim to your dental insurance carrier for services rendered as an out of network provider. Please note that when we call your insurance provider, to verify benefits, it is not a guarantee of payment by your insurance company. Furthermore, any treatment plan that is proposed for the treatment of your dental needs/desires is an estimate of cost base on the information provided by your insurance carrier. It is not a guarantee of insurance coverage for services. If you would like to know exact costs for treatment, a pretreatment estimate can be submitted to your insurance carrier. You must specify this to our team prior to initiating treatment. (This could take 4-6 weeks time)

Patient Initials: _____

Please remember that the contract itemizing your dental benefits is an agreement between you, your employer, and your insurance carrier. Regardless of coverage, your estimated copayment for services is due the day of treatment. If your insurance company does not pay within 90 days of service, you then become responsible for the outstanding balance for services rendered. It is then up to you to seek reimbursement from your insurance carrier. In the case your insurance carrier pays more than is owed for treatment, a credit will be applied to your account, or a refund will be processed. Remember that insurance plans are not designed to cover all of your treatment needs.

I, _____, have reviewed this information and consent to allow Island Grove Dental to file to my insurance claims for services rendered as an out of network provider. I accept full responsibility for all patient accounts that I am deemed responsible for, personal and family. I acknowledge that it is my responsibility to be aware of the type of insurance that I am utilizing for my dental services. I also acknowledge that Island Grove Dental cannot guarantee that my insurance carrier will cover all services rendered during my dental treatment, and that I was provided with an estimated cost of benefits. Finally, I acknowledge that after 120 days, I become the responsible party for all costs for services rendered and that I will be responsible for seeking reimbursement from my insurance carrier at that time.

PATIENT NAME: _____ DATE: _____

SIGNATURE: _____