Patient Acknowledgement
of Financial Responsibility

Dental insurance is a contract between a patient and their insurance company often facilitated by an employer. The extent of coverage varies depending on the specific policy you have. As a courtesy, we will submit dental claims to your insurance for you and will try our best to help you understand your coverage. **Ultimately it is your responsibility to know the details of your plan**. All questions regarding your insurance coverage must be addressed by you to your insurance company. Ultimately, your treatment should be determined by you and your dentist – not by your level of dental coverage. Optimum oral health often requires more than the bare minimum that a policy allows.

Insurance companies never guarantee benefits. Some required treatment may not be a covered benefit of your policy. We are happy to provide these services but want our patients to understand the financial implications. Many insurance companies are either unaware or ignore the state law and indicate on an EOB that the patient does not owe any more for the services provided, when in fact there may still be a balance due by the patient. In 2012 the Legislature passed LB 810 to address a situation occurring with insurance dental plans, specifically, an insurance company attempting to limit the fee a dental office could charge a patient even though the dental plan did not provide a benefit for a particular procedure sought by the patient. LB 810 modified §44-7, 105 which is below:

§ 44-7, 105. (Effective 7/19/2012)

Notwithstanding section 44-3, 131, (1) an individual or group sickness or accident policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state and a hospital, medical, or surgical expense-incurred policy, (2) a self-funded employee benefit plan to the extent not preempted by federal law, and (3) a certificate, agreement, or contract to provide limited health services issued by a prepaid limited health service organization as defined in section 44-4702 shall not include a provision, stipulation, or agreement establishing or limiting any fees charged for dental services that are not covered by the policy, certificate, contract, agreement, or plan.

Any balance not paid by your insurance is your responsibility. This may include differences between the fees allowed and a downgraded fee, a service not covered under your plan, or any service completed that is within the guidelines of your policy but not paid by insurance. The **estimated portion** will be due at the time of treatment unless prior arrangements have been made. After all claims have been received back from insurance a final statement may be mailed to the patient if a balance remains. If an overpayment has occurred, a refund will be issued to the patient.

________ ***(Initials)***

Financial Options

We are committed to supporting you in understanding your dental health and will always present you with the best dental options possible to address your personal health situation. We are pleased to offer you the following payment options:

Patients **without** insurance coverage may receive **one** of the following:

- 5% discount when services are **paid for in full with either cash or check** the day of treatment.
- 10% discount for senior citizens and military personnel.
- Patients have the opportunity to utilize our “On Call Club” discount for recall appointments.

Visa, MasterCard, Discover, Cash and Check are accepted.

Care Credit with no interest payment plans for up to 12 months.

I agree that I am fully responsible for the total amount of all procedures performed at Pine Ridge Dental. I understand that all payments are due within 60 days of the date of service. I understand that at 60 days my account will accrue interest at 16% annually and balances over 90 days are subject to collection activity.

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In the case of a divorce: Pine Ridge Dental will not be involved in disagreements between the parties involved and will not make special arrangements for payments on balances due between the parties. It is ultimately your responsibility to come to an agreement to make sure all balances due are paid in full.

Appointment Agreement

We value our patients and reserve a set amount of time in our schedule to ensure you receive quality care. Should you need to cancel or reschedule your appointment we ask that you give a 24-hour notice, or you may be subject to a $50 broken appointment fee. Our goal is that you have an outstanding experience at Pine Ridge Dental. If you have additional questions, please speak to one of our administrative team members for further information.

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Common Examples of Limitations in Dental Benefit Plans

1. **Frequency Limitations –** Limitation: Dental cleanings and exams are benefits normally allowed only twice per Benefit Period. Although many patients would benefit from a third cleaning each year, a third cleaning or exam (EX: Comp/Periodic/Limited) may not be covered by your plan. X-rays are required for Diagnosis and may have a frequency that limits insurance coverage.
2. **Topical Fluoride Applications –** Limitation: Topical fluoride is a benefit normally for eligible children under a specific age once every 12 consecutive months. Therefore, a second application within 12 months is not covered. Fluoride varnish after cleaning is recommended for patients of all ages, not just for children.
3. **Periodontal Maintenance Therapy –** Limitation: Periodontal Maintenance Therapy is normally covered twice per year. A third Periodontal Maintenance Therapy in the same year may not be covered.
4. **Alternate Benefit Services:** A filling for example, we provide composite (tooth colored) fillings. Some dental benefit plans do not “cover” a composite filling and will only pay a percentage of an amalgam (silver colored) filling. The same example applies for steel and tooth-colored crowns. Insurance will pay on the lesser valued code, and the patient is then responsible for the difference. This is referred to as a Downgrade.
5. **Annual Benefit Cap –** Most Dental Benefit Plans have an annual cap or maximum (usually between $1,000 and $2,000 per year). If any dental service is provided and you have exceeded your annual benefits, the service will not be covered by your insurance.
6. **Waiting Periods –** Some plans require a waiting period before a patient’s benefits begin to take effect. If you as the patient have not waited long enough for the benefit to begin, the service is not covered by your insurance.
7. **Missing Tooth Clause –** Most insurance companies will not pay to have a tooth “Replaced” if the tooth was extracted/missing prior to the plan’s start date.
8. **Replacement Clause –** Most insurance companies will only pay for a covered benefit on the same tooth outside of a specific time frame. SRP/Crowns/Fillings may have a frequency limitation, and therefore will be the patient’s responsibility if completed within this specified time within your policy more than once.

The above examples are only a partial list of limitations and exclusions that appear in dental benefit plans that apply to coverage.

If the Dental Benefit Plan never pays for rendered services, then the service is not “Covered by the policy” and the Dental Benefit Plan cannot dictate the price for that service.

Be sure to check your dental benefit plan for a complete list of limitations and exclusions

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Patient/Guarantor Signature Date Please Print Patients Name