CEDAR VALLEY DENTAL
Pompilia C. Belean, D.D.S.
FINANCIAL POLICY

Thank you for choosing Cedar Valley Dental as your dental provider. We welcome you and your family to our practice, and look forward to providing you with excellent dental care.

In an effort to make dentistry more affordable for our patients, we participate in several types of dental benefit programs. It is the responsibility of the patient to verify their own coverage information and file claims on completed services. As a courtesy we will be happy to do this for you! Please make sure that you inform us of any coverage changes as soon as you are aware of them so we can update our records.

**** Please be aware that insurance companies will NOT *guarantee* any coverage until services have been performed and a claim has been filed.****

Upon reviewing treatment plans with you for any necessary work, we will do our best to estimate what your insurance company will cover (what the total "allowed" fees will be, how much they will pay and what your portion will be). You will receive a copy of the Explanation of Benefits from your insurance company that will detail all payment information by them and what is expected of you.

It is the patient's responsibility to pay for services at the time they are rendered, even with dental insurance coverage. As a courtesy, we will allow patients to pay just their estimated co-payment amount at the time of services. Once a claim payment is made by the insurance company, we will either collect the additional patient portion or issue a refund for any patient overpayment. Claims are submitted promptly after treatment is rendered, and if unpaid by your insurance carrier within 60 days of the treatment, the patient will be billed for any unpaid balance.

By signing below, I understand that I am financially responsible for all charges incurred. I hereby assign my insurance benefits to Cedar Valley Dental. I also authorize Cedar Valley Dental to release any necessary information to my insurance carrier for the processing of claims.

Print Patient Name: _____ Date: _____

Signature of Responsible Party: _____