Insurance Information and Release Form

Child(ren)'s Name _____ Date of Birth _____

Insured's or Subscribers Name _____ Date of Birth _____

Insured's Social Security Number _____ Insurance ID Number (if known) _____

Employer _____

Insurance Company Name _____ Group Number _____

Insurance Company Address (Street or P.O. Box) _____ Insurance Company Telephone _____

(Insurance) City/State _____ Zip _____

Release of Information:

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signature of Parent/Guardian _____ Date (Mo/Day/Yr) _____

Authorization to Pay Dentist:

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. James M. Brittain.

Signature of Parent/Guardian _____ Date (Mo/Day/Yr) _____

PLEASE FAX (704.372-2869) OR MAIL BACK PRIOR TO YOUR APPOINTMENT

Dental Insurance Agreement

We are excited and happy that your employer has chosen to provide your family with dental insurance benefits. In order to provide you with the best possible service, we need a completed "information and release form" (attached). We would also like for you to know and understand our relationship with dental insurance.

Our commitment to you:

1. We will gather appropriate personal information from you in order to process your claims and will use this information solely for that purpose. (see HIPPA brochure)
2. In most cases, claims will be submitted electronically; a few carriers require paper claims.
3. While we make every effort to have a comprehensive understanding of most policies, there are some insurance companies which provide limited information; therefore, we ask your help in becoming your own "expert" on your group or individual policy.
4. We will provide the correct procedures and American Dental Association coding to your carrier. If there is an error on our part, we will make every effort to correct it.
5. We will resubmit *twice* claims that are "not received" by your insurance company.
6. We will follow up with your insurance company to verify receipt of your claims. If, after 60 days, your carrier has not processed and/or paid our claim, the claim will be released to you. This means you would pay us directly and your insurance will reimburse you.
7. We will file and accept assignment of benefits for ***primary coverage only.*** If you have secondary coverage, we will provide a "superbill" for you to attach to the secondary claim form along with your copy of the primary carrier's explanation of benefits.

What we expect from you:

1. Accurate, up-to-date information necessary to process claims.
2. Updating any personal or employer/insurance changes as they occur.
3. Assisting us with understanding and knowing the provisions of your particular policy.
4. *Prompt* response to your insurance company's inquiries about coordination of benefits or dependent status. Claims delayed more than 60 days for these reasons will be released to you for your payment directly to us.
5. Most Delta, out of state Blue Cross/Blue Shield, Anthem or Horizon Blue Cross participants will pay us directly at the time of service and will be reimbursed by your insurance company.
6. Co-payment (the amount not covered by your insurance) is due at the time services are rendered.

I have read and understand to my satisfaction the above information. By signing the below I acknowledge and accept the terms of this agreement.

Signature of Parent or Guardian	Date	Child(ren)'s Name