PEDIATRIC DENTISTRY
OF UNION

Understanding Dental Insurance

We have prepared this letter to help our patients understand the complexities of dental insurance. We realize how confusing it can be. To begin, we would like to highlight a misconception: dental insurance is **NOT** designed to pay for all your dental care. Most contracts have yearly limits, treatment limitations and/or various degrees of "co-payments".

Our fees are based upon a combination of our costs, our time, and our consistent dedication to providing our patients with the highest quality of dental care. Our office participates with several different dental insurance companies as both a contracted provider or "in-network" and non contracted provider " out of network".Our doctor's treatment recommendations are based on their clinical findings and not based on what your insurance company allows. How you proceed with treatment is ultimately your decision.

Please understand the dental insurance contract is between the insurance company and the patient. Our office does submit all claims for treatment provided to your insurance company on your behalf. If you are unclear as to whether a particular procedure is covered by your insurance carrier, please contact them directly with any questions. For further clarification you may request our office submit a predetermination on your behalf. Predeterminations are used as a tool to determine plan coverage; however it is **NOT** a guarantee of plan payment.

We hope this information has been helpful. Please take the time to review your insurance policy thoroughly so that we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

I certify that my child is covered by the insurance company provided and I assign directly to Pediatric Dentistry of Union all the insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Patient/Legal Guardian Signature:_____ Date: _____