R. L. Daschbach & Associates
Office Financial Policy Agreement

These insurance companies below are IN-NETWORK at our office. We will submit the claims for you. You are responsible for your ***estimated*** portion at the time of service. We will bill you for any balance after the insurance payment is received. You may have a balance due beyond your estimated payment.
Please indicate which IN-NETWORK insurance you will be using:

Sunlife	Yes___	No___	initials _____
Blue Cross/Blue Shield GRID+	Yes___	No___	initials _____
Anthem GRID+	Yes___	No___	initials _____
Cigna PPO	Yes___	No___	initials _____
Delta Dental Premier/PPO	Yes___	No___	initials _____
United HealthCare PPO	Yes___	No___	initials _____
Lincoln Financial Group	Yes___	No___	initials _____
Guardian DentalGuard Preferred	Yes___	No___	initials _____

These other insurance companies are OUT-OF-NETWORK.
If your dental insurance provider is **OUT-OF-NETWORK**, we will gladly submit your claim. However, out of network fees **will** apply. An estimated fee will be calculated and **due the day of service.** *Please keep in mind: Insurance companies that are out of network may say they will pay 80% of allowable fee. This means they will pay 80% of THEIR allowable fee, not 80% of our fee.*

Aetna	Yes___	No___	initials _____
AmeriHealth	Yes___	No___	initials _____
Cigna PPO Advantage	Yes___	No___	initials _____
Guardian	Yes___	No___	initials _____
Everence	Yes___	No___	initials _____
Humana	Yes___	No___	initials _____
Metlife	Yes___	No___	initials _____
Principal	Yes___	No___	initials _____
Pro Benefits	Yes___	No___	initials _____
Populytics	Yes___	No___	initials _____

We want to emphasize that as dental care providers, our relationship is with you as our patient, and not with your insurance company or employer. Although we will file dental claims with your insurance company, all unpaid charges are ultimately the patient's responsibility.

- In consideration of the services provided to me by the office, I agree to pay in full my estimated portion at the time of service. I also agree that I shall be responsible if a balance remains once insurance has paid and will pay it in a timely manner.
- I grant permission to you and the staff to telephone me at any time to discuss matters related in this form (this includes my immediate family who are under my insurance)
- I have read and fully understand the conditions of treatment.

I read and understand the office financial and cancellation policy.

_____ _____
Patient Name If minor, printed name of responsible party

_____ _____
Signature of responsible party Date