_____
PRINT NAME

JAMES S. TRICHAK DENTISTRY
16841 N. 31st AVE., #140
Phoenix, AZ 85053

INSURANCE AGREEMENT

For our patients who are requesting that this office carries a balance on their account, in anticipation of insurance payment. This form must be read and signed by the patient or responsible party before we can submit for payment directly from an insurance company.

1. I understand and agree that the amount estimated to remain unpaid by insurance is to be paid by me at the time of treatment.

2. I understand that this office cannot make an exact estimate of the anticipated benefits due to the diversity in insurance plans, policies, and provisions.

3. I understand and agree that after the insurance company pays, there could still be a remaining balance which I will pay in full within 10 days of billing.

4. I understand that this office cannot wait more than 60 days for payment from my insurance company. If the claim is not paid in that time the entire amount is due and payable by me.

5. I understand that this office, as a courtesy to me, will submit claims to my insurance company at no charge. It is my responsibility to provide this office with all necessary information. If a claim needs to be resubmitted due to my failure to provide updated information there will be a $15.00 charge for each claim.

6. I understand and agree that if the estimate of insurance benefits indicates a large amount due by me which I feel I cannot pay at the time of treatment, I must discuss and make financial arrangements prior to scheduling treatment.

7. I understand that recommended treatment is based upon patient's dental health needs, NOT on insurance benefits. The determination of proper treatment is a matter best decided by the patient and Dr. Trichak. It is not a matter to be dictated by an unseen third party whose total motivation is the protection of the insurance company profit margin.

8. I understand that my insurance is a contract between me and my carrier and not this office. I realize this office cannot know all the clauses, exclusions, limitations and eligibility of my insurance plan. It is my responsibility to question my insurance administrator if I have concerns. A pre-determination of benefits is not done routinely in this office. This office will submit a pre-determination, one time, for any procedure requiring x-rays upon my request.

PLEASE SIGN ALL *3* LINES * THEY ARE EACH SEPARATE AGREEMENTS

X_____ Date_____
I authorize the release of any information necessary to process my insurance claim

X_____ Date_____
I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me.

X_____ Date_____
I have read, understand, and accept the terms of the above insurance agreement.

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INSURANCE INFORMATION WORKSHEET

_____ _____
FAMILY LAST NAME DATE

Name of Policy Holder _____

Date of Birth _____ Social Security_____ Insurance ID_____

Employer/Company _____

Insurance Company _____

Address _____

Phone # _____ Group # _____ Effective Date _____

Other Family Members Insured on this plan and their birthdays

_____

_____

ARE ANY COVERED BY AN ADDITIONAL INSURANCE PLAN? (If so fill out another form also)

COVERAGE INFORMATION **(FOR OFFICE USE)**

Annual Maximum _____ Deductible per person _____ Deductible per Family _____

Is deductible waived for any procedures ? prev._____ diagnostic _____ pallative _____ Sp maint _____

% of coverage for: Preventive _____ Basic _____ Major _____ Endodontist _____

Perio _____ Oral surgery _____ Sealants _____ Palliative _____ orthodontics _____

Occlusal guards _____ Are there waiting periods? _____ Are there age limitations?_____

Are there time limitations for any procedures? Fmx _____ bw _____ fluoride _____

Cleanings _____ crown replacement _____ Dent/part replacement

Does plan pay on a calendar year? _____ If not the benefit year begins, _____

Is there a standard coordination of benefits? _____