BEAVERTON PERIODONTICS & IMPLANT SOLUTIONS

Patient Financial Responsibility

Cash or Non-Insured Patients

- Your first visit/initial examination is a charge of $140-$199 and is due in full at the time of the service. Treatment appointments will be collected a week to 10 days before appointment.

Understanding Your Insurance Coverage

- Your insurance is a contract between your employer and your insurance carrier.
- Insurance works like a valuable "coupon" that can reduce the cost of dental care.
- Not all services are covered by insurance, only those contracted with your employer.
- Each patient's insurance policy is different.
- It is not possible for us to know all the details of your policy.
- You are responsible for understanding the details of your insurance coverage.

Processing Claims (a request for insurance payment) for Services Rendered

If you would like us to submit claims on your behalf, please:

- Provide a copy of your current insurance card(s).
- Complete and submit the Patient Information form.
- Alert our office of any changes in your insurance coverage.

"Best Guess" Estimates

As a courtesy, we will contact your insurance company to gain general information about your coverage. This will enable us to make a "best guess" estimate as to what they will pay for and what they will expect you to pay for regarding the services and treatment you receive.

This "best guess" estimate will be given to you as a printed-out Treatment Plan that breakdowns the Service Codes for each treatment or combination of treatments recommended by the doctor.

We encourage you to contact your insurance company and review the Service Codes with them, the costs of services, and what they anticipate they will pay for you to have all the information about any financial portion that will be your responsibility to pay.

Our "best guess" estimates are based on the general information provided by your insurance. **Any portion of your treatment that is not covered by insurance will be your responsibility to pay directly to Beaverton Periodontics prior to receiving treatment.**

Authorization

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

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Signature of Patient, Parent, or Guardian Date