Financial Arrangements & Dental Insurance

We strongly feel our patients deserve the best possible dental care we can provide. Part of this care is a comfortable relationship between our team and you, the patient. In an effort to maintain this high quality of care we believe it is important to avoid misunderstandings. We have found that some misunderstandings have to do with insurance and our office's financial policy. Therefore we would like you to read the following information. If you have additional questions please feel free to ask one of our staff members.

Payment

Payment is due at the time services are rendered unless prior arrangements have been made with our staff. We accept cash, personal checks, money orders, Visa, MasterCard, Discover, American Express and in some cases CareCredit. A service charge of $30.00 will be added for returned checks. Balances over 60 days will incur a 1.5% service charge for each month the account is left unpaid. An additional charge of 20% of the total bill will be added if an account is not paid within 12 months and is sent to our collection agency. In order to avoid a broken appointment fee of $30.00 for a missed appointment with the Hygienist and $50.00 charge for a missed appointment with Dr. Bork, we ask that you contact our office 48 hours in advance, if you need to cancel an appointment.

Dental Insurance

If you have dental insurance, we will be happy to process it for you if you supply us with all the necessary information. You can choose to assign your insurance benefits to Dr. Bork provided you complete and sign the assignment and release section of our blue form. We will then forward the claim to your insurance company for their possible payment towards services rendered. We **cannot** make these arrangements unless we have all the required information at the time of your visit. If we do not have the information, we require full payment at time of service.

Please note:

- Your insurance is a contract between you, your employer and the insurance company we are not a party to that contract. We are not responsible for any lack of plan benefits or determination of payments. The financial obligation for dental treatment is between you and our office. We work with your insurance as a courtesy to you, our patient.

- Our fees fall within the acceptable range by all insurance companies and are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "usual, customary and reasonable" fees. **This does not apply** to companies who reimburse on an arbitrary standard cost of care (fee schedule).

- Not all services are covered by insurance. If you have any doubts about coverage, get a "predetermined cost" from your insurance company.

- Rarely does an insurance company pay 100% for all services rendered. Because of this, if we agree to accept assignment of benefits, we will then check with your insurance to get a brief explanation of benefits this will then give us an idea of how they will pay and then we may **estimate** what portion will be the responsibility of the patient and that portion will be due at the time services are rendered. **This is only an estimation of what may be uncovered by your insurance company**. If we receive a payment from your insurance that is higher than what we estimated, we promptly refund payments made by you for those same charges. If we receive less from your insurance, the remaining balance will need to be paid by you. If the services are not covered by your insurance for any reason at all, the entire amount will be payable by you.

Please complete below information

Date__________________

Patient's Name____

Address____

Social Security Or ID#_________________________ Date of Birth________________________

Who is financially responsible for payment on the above patients account?

Name____

Address____(circle here if same as above)

Social Security Or ID #_______________________________

Employer____

Spouse's Name____

Spouse's Social Security Or ID#______________________

Spouse's Employer____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I have read all the information on this page and have completed the above. I certify this information is true and correct to the best of my knowledge.
I will notify Dr. George F. Bork's office of any changes in the above named patient's health status or the above information.

____ __________________________

Signature of person responsible for the account Date

____ Check here if patient is a minor and signature is the parent or guardian.