OPTIMAL DENTAL CENTER
General and Cosmetic Dentistry-Designing Smiles

8303 Arlington Blvd. Suite 107
Fairfax, VA 22031

Phone (703) 226-2222
info@optimaldentalcenter.com Fax (703) 573-6180

FINANCIAL POLICY WITH INSURANCE COVERAGE

Dear Patient,

We participate with most insurance policies, except HMOs. We will process your insurance claims but request that you pay your estimated portion at the time of service.

Although we do our best to gather your personal dental coverage information, we would like to inform you that it is impossible for our office to be completely familiar with a particular plan and/or insurance limitations. Your insurance is a contract between you, your employer, and the insurance company. As an outside party, our ability to obtain specific plan details is limited. Even though we will do our best to work alongside your insurance, it is impossible for our office to *guarantee* the benefits your insurance will provide.

I, _____, understand that my insurance is my personal responsibility. As a courtesy to our family, Optimal Dental Center's staff will assist us with insurance verification and an estimate of my benefits. Additionally, I understand that ANY AMOUNT NOT PAID BY INSURANCE COMPANY for ANY TREATMENT/SERVICES performed at Optimal Dental Center is my responsibility and that any remaining balance must be promptly paid to prevent further collection process.

ASSIGNMENT OF BENEFIT-MEDICAL INSURANCE if applicable

There are procedures in a dental office that might be payable by medical insurances hence releasing dental benefits to dental specific treatments. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **OPTIMAL DENTAL CENTER** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

_____ I understand the above information and have been given the opportunity to ask questions.

_____ _____

(Patient Signature) **(Date)**