Appleway Dental Clinics

DIRECT BILLING YOUR DENTAL INSURANCE

Our office will extend the courtesy of directing billing (accepting assignment of benefits) to your insurance company with the following provisions.

It is important to understand, though, that the contract regarding your dental benefits is between **you and your insurance company**. Under this agreement, you agree to pay for any account balances in full for treatment rendered, regardless of the amount covered by your dental insurance company.

- We, **Appleway Dental Clinics**, agree to submit your completed dental claim electronically or manually on your behalf with payments to be allocated to our office. We hold no responsibility for amounts **not** covered by your dental plan or coverage frequencies.
- You, **the patient/parent or guardian** will be required to pay the co-pay on the day services are rendered. Should we not receive an "Explanation of Benefits" the day services are rendered, you **the patient/parent or guardian** agree to have the balance cleared by the credit card below, once we receive your insurance payment(s).
- We, **Appleway Dental Clinics**, agree to contact you by phone/mail/voicemail/email to notify you of the balance to be posted to your credit card after insurance has paid. A receipt will be mailed to you with copy of your insurance payment(s).
- **If you do not have a credit card**, we will submit your claim, payable to the policy holder and we ask all your balances be paid on the day of service. As an alternative to this option, we will collect an estimated portion after your appointment if we do not receive a complete breakdown from your insurance. Please advise our office of which option would best be suitable for you.
- Payments are usually received within 30-45 days from insurance companies. Should we not receive payment from your dental plan within 60 days, we will require you, **the patient/parent or guardian** to clear your account in full. It will then become your responsibility to pursue reimbursement from your insurance company and we can assist you in reprinting forms if need be.

I, **the patient/parent or guardian,** agree to any outstanding balances after my insurance claim has been received and posted to my account, to be billed to the credit card provided below. I acknowledge that any outstanding balances of 65 days or more are subject to ***an interest charge of 28% per annum***. I assume responsibility for all costs, should I have any delinquent balances forwarded to a third party collections agent. (45% administrative fees apply for collection accounts)

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Signature of patient, parent or guardian **Date**

CREDIT CARD INFORMATION FOR DIRECT BILLING COURTESY

Visa/MC # _____ **Expiry:**_____

_____ _____

Office Authorization **Date**