Bedford Dental Care
Insurance and Payment Policy

1. Payment is due when services are rendered. All insurance co-payments are to be paid in full at the time of service.
2. You must provide this office with a copy of your current insurance card, including identification number, policy or group number, claims mailing address claims or customer service telephone number. If you change plans YOU MUST notify us IMMEDIATELY.
3. Our financial Department will call to check insurance benefits, eligibility and unpaid deductibles on all new patients and share this information with you. We cannot guarantee the information we receive and pass on to you is absolutely correct, however.
4. Claim denials by the insurance company are the patient/guardian's responsibility, unless the denial is for untimely claim filing due to no fault of the patient. (Claims will be filed within 30 days of date of service providing insurance information is correct.)
5. Insurance exclusions and non-covered services are responsibility of the patient/guardian.
6. Resubmission of lost/unprocessed claims will be traced and refilled one time by this office. We will make every reasonable effort to collect payment from your insurance company, but if the insurance company does not pay your claim with in 90 days of timely and correct filing, the balance due will be transferred to you.
7. **FILING YOUR INSURANCE CLAIMS IS A COURTESY NOT A REQUIREMENT IN THIS OFFICE. WE HAVE THE RIGHT TO REFUSE TO FILE ANY INSURANCE CLAIMS AT OUR DISCRETION. THE PATIENT/GUARDIAN IS RESPONSIBLE FOR CONTACTING THEIR OWN INSURANCE CARRIER TO OBTAIN PAYMENT IF BALANCE IS TRANSFERRED TO YOU. THIS OFFICE WILL PROVIDE YOU A PAPER CLAIM WITH CORRECT ADA CODES FOR YOUR CONVENIENCE, BUT WILL NOT BE RESPONSIBLE FOR ANY CLAIM DESPUTES WITH THE INSURANCE COMPANY. THE PATIENT/GUARDIAN IS ULTIMATELY RESPONSIBLE FOR THE TOTAL BALANCE DUE.** (this includes underpayment, non-payment or out of network payment by their insurance.)
8. In the case of overpayment by insurance company and/or responsible party a reimbursement will be issued to the responsible party. (Or if you prefer a credit will be left on your account for future services.)

Authorization:

I authorize this office to release any information pertinent to my case to my insurance company in order to facilitate claim processing and collect payments for services rendered. I also agree t have the insurance payment sent directly to Bedford Dental Care

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(Signature) (Date)