JATIVA FAMILY DENTAL

WENDY JATIVA DDS, MS

Dental Insurance Information

Primary Insurance

Name of Insured:_____ Date of Birth_____

Social Security Number:_____-_____-_____ Subscriber ID#:_____

Insured Employer: _____ Group #:_____

Relationship to Insured: __Self __Spouse __Child __Other

Secondary Insurance

Name of Insured:_____ Date of Birth_____

Social Security Number:_____-_____-_____ Subscriber ID#:_____

Insured Employer: _____ Group #:_____

Relationship to Insured: __Self __Spouse __Child __Other

Assignment of Benefits

I hereby assign all dental benefits, to include major medical benefits to which I am entitled. I authorize and direct my insurance carrier to issue payment checks directly to Jativa Family Dental for dental 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.

Do you have insurance?

* As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Please contact your insurance company for a copy of your dental benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible.

* All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company.

* Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits.

* Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy.

* Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that our account maybe credited accordingly.

* Your claim will be filed Immediately, and benefits are expected are to be paid within 30days. If the claim is not cleared by your dental carrier within 45 days, the unpaid portion will automatically become “self pay” and a statement will be issued to you for the unpaid portion. You are responsible for any amounts

No Insurance. No Problem

* We accept cash, checks, all major credit cards (Visa, MasterCard, Discover, American Express) as options for you. Most of our visits require payment in full at the time of service. Other payment options may be available for our patients if these arrangements are made with Marcy prior to scheduling your treatment.

If you have any questions, please do not hesitate to ask. We are here to help you receive the dentistry that you want or need!

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Authorization and Release

I understand that I am financially responsible for all charger whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Patient/Guardian Signature: _____Date: _____

Print Name: _____Relationship to Patient: _____