James A. Richardson, D.M.D., L.L.C.

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care, if you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We will be happy to process your insurance. **All insurance information must be complete and up to date.** A copy of your dental card is requested. All Estimated Co-pays are only **"estimates."** If balances are left after Insurance Payment has been received, **You will be billed for the difference.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies to companies who pay a percentage of "U.C.R." The U.C.R. is defined as *usual, customary and reasonable fees* for this region. This statement does not apply to ALL companies.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

DENTAL INSURANCE

PRIMARY INSURANCE

Employer ______________________________ Carrier ______________________

Subscriber: Name ______________________________ Address ______________________

SSN ______________________________ Plan or Policy # ______________________

Date of Birth ______________________________ Phone # ______________________

Your relationship to subscriber: Self Spouse Child Other

SECONDARY INSURANCE

Employer ______________________________ Carrier ______________________

Subscriber: Name ______________________________ Address ______________________

SSN ______________________________ Plan or Policy # ______________________

Date of Birth ______________________________ Phone # ______________________