Elisabeth M. Gerics DDS PA

Today's Date _____

Welcome!

Thank you for choosing our practice for your dental needs! Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Name _____ Birthdate _____

Social Security Number _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Extention _____

Email Address _____ Cell Phone _____

Patient's Employer _____ Occupation _____

Business Address _____ How Long Held _____

Spouse's Name _____ Birthdate _____

Work Phone _____ Extention _____ Cell Phone _____

Social Security Number _____

Spouse's Employer _____ Occupation _____

Business Address _____ How Long Held _____

In Case Of Emergency, Notify **(Please list names other than spouse)**

1) _____ Phone _____ Relationship _____

2) _____ Phone _____ Relationship _____

Name Of Primary Insurance Company _____

Name Of Policy Holder _____

Policy Number _____

- Please provide us with your insurance card and benefits summary if you would like us to file your insurance -

Whom May We Thank For Referring You? _____

- OVER PLEASE -

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE
Office of Elisabeth M. Gerics DDS PA

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, AmericanExpress or DenCharge.

Returned checks and balances older than 45 days will be subject to additional collection fees and interest charges of 1 ½% per month (with a $5 minimum billing fee per month). To avoid finance charges, payment may be made in full at each visit.

CHARGES MAY BE MADE FOR BROKEN APPOINTMENTS AND APPOINTMENTS CANCELLED WITHOUT 24 HOURS ADVANCE NOTICE.

If you have dental insurance, we are anxious to help you receive your maximum allowable benefits.
We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances we may accept assignment of insurance benefits. In the event that payments are not received **promptly** by your insurance company, the balance is due and payable in full by you, and you are to contact your insurance carrier for your reimbursement.

You must realize, however, that:
1) Your insurance is a contract between you, your employer and the insurance company. We are not 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 only to companies who pay a percentage of "UCR." "UCR" is defined as usual, customary and reasonable by most insurance companies. Bear in mind that this office does not provide merely "usual and customary" care and your insurance company may not take your ideal care into consideration when setting its limitations.
3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover and your employer may have chosen to limit your coverage.

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. 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.

AUTHORIZATIONS:

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand and agree that I am ultimately financially responsible for all charges whether or not paid by insurance.
I have read all the information on both sides of this sheet and have completed the answers. I certify this information is true and correct to the best of my knowledge.
I will notify this dental office of any changes in my health status or the enclosed information.

I have received a copy of this office's Notice of Privacy Practices.

Signature_____ **Date**_____