Greenview Dental Care

2516 Samaritan Drive Ste I | San Jose CA, 95124 | (408) 356-8201

FINANCIAL POLICY

Insurance Coverage

The following financial policy applies to all patients who have insurance coverage. Please carefully read and sign this agreement providing you agree with it. Let our finance staff know if you have any questions.

1. We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, remember that paying for your treatment is your personal responsibility. We will verify your insurance benefits by contacting the insurance company. You will need to sign an "Assignment of Rights and Benefits" so we can accept your insurance coverage.

2. You will need to pay your portion of the charges as you go. This includes the annual deductible, co-payment, and charges your insurance company refuses to pay. While our office policy does not allow us to extend credit, we accept American Express, MasterCard, VISA or Discover card for these charges.

3. Once your insurance payment has been received your account will be balanced. We will either owe you a refund or you will owe us a payment.

If you have a refund due, how would you like us to handle it?
❒ Apply the refund to my account for future treatment.
❒ Mail check to:
Name and Address:_____
_____
_____

If your insurance company does not pay or if you owe us an additional payment, you will be responsible for payment.

4. Occasionally, an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important. Also, your insurance company may request additional information from you. They will not pay your claim until they receive the information, so please send it immediately.

5. If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by your insurance company will become immediately due and payable by you personally before you leave.

By signing below you agree to the terms of this policy.

_____ _____

Patient Name (parent/guardian if patient is a minor) | Signature | Date