DENTAL INSURANCE FILING POLICY
FOR THE OFFICE OF
STEPHANIE SNELSON, D.D.S.

We would like to make you aware of our general policies regarding the filing of dental insurance:

1. If you are a patient with an insurance company with which we have a participating provider agreement, we will automatically file an insurance claim for the dental work performed in our office. We will provide you an ESTIMATE of the projected amount to be paid by your participating insurance provider. You will be responsible for any co-payment or deductible per your agreement with your dental insurance company.

2. If you have dental insurance with a company we do not participate with, we will file a dental insurance claim on your behalf. Please realize we can only provide you an ESTIMATE of what your insurance company may pay. What your insurance company actually pays may differ substantially from our estimate. This situation is out of our control. The patient is financially responsible for the cost of all dental work performed in this situation. The insurance claim is simply filed as a courtesy.

3. Regarding the filing of secondary insurance policies, we are happy to assist in most cases. However, we do limit the filing on a secondary insurance policy to one (1) secondary policy. It is impossible for us to predict what balance may be left regarding a patient balance after a secondary insurance claim is filed. Any estimate provided to the patient is simply an estimated amount. The patient remains fully responsible for the actual amount due.

In the event of default in payment of any amount due, after thirty days, the undersigned agrees to pay a service charge in an amount not exceeding 1.5% per month on this account. Further in the event this account is referred to an attorney or collection agency, the undersigned agrees to pay reasonable attorney's fees and court costs, or collection fees of up to 50%. There is also a $25.00 service charge on all returned checks.

I HAVE READ AND UNDERSTAND THE ABOVE INSURANCE AGREEMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY FEES NOT COVERED WITH MY INSURANCE.

Signature: _____

Date: _____