Patient Name: _____

Better Living through Dentistry
155 W. 68th St., New York, NY

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company Name: _____

Insured's Name: _____ Relation to Patient: _____

Group Number: _____ Insured's Policy ID Number: _____

Insured's Date of Birth: _____ Insurance Company Phone: _____

Insured's Employer: _____ Insured's Work Phone _____

Secondary Dental Insurance

Insurance Company Name: _____

Insured's Name: _____ Relation to Patient: _____

Group Number: _____ Insured's Policy ID Number: _____

Insured's Date of Birth: _____ Insurance Company Phone: _____

Insured's Employer: _____ Insured's Work Phone _____

OFFICE INSURANCE POLICY AND ASSIGNMENT OF BENEFITS - PLEASE READ CAREFULLY

I understand that an insurance policy is not a guarantee of payment. While every effort will be made to insure the accuracy of my insurance plan benefits, I understand that the office estimate of my insurance benefits is NOT a guarantee of accuracy and in fact will **not be exact**. I understand that a pre-determination of benefits will result in the most accurate estimate of my insurance plan benefits, however even a pre-determination of benefits is NOT a guarantee of payment by the insurance company.

I understand that the office will file for a pre-determination of benefits only on estimated claims exceeding $500.00 and that a pre-determination of benefits may take in excess of six weeks to be processed by my insurance company. I understand that the filing of my insurance claim is a courtesy extended by the office and that the office is not an agent for my insurance company, and has no control or influence over them, their policies or their payments.

I understand that my insurance company has not examined me and does not know my dental condition and dental needs. I understand that my insurance company may deny payment or change the treatment to a lesser cost treatment option and that this is done strictly for the economic benefit of my insurance company and not to my personal benefit. I understand that my insurance company may not pay for certain materials or procedures and that this is done for the economic benefit of my insurance company and not for my benefit. I understand that Dr. Kong/or his associate will recommend and use materials and treatment procedures that are in my best interest and not based upon my insurance company's payment considerations.

I agree to be responsible for the full amount of the charges for my treatment. If I elect to have payment (if any) made to Dr. Kong/or his Associate by my insurance company, this will be applied towards the full amount of charges for my treatment.

I hereby authorize the release of any information pertaining to my treatment and claim to the above insurance companies and their representatives. I authorize the release of my information to the above insurance companies by electronic submission through national clearing houses that are governed by the HIPPA privacy act.

I hereby authorize payment to be made directly to Dr. John Kong of the group insurance benefits otherwise payable to me.

☞ Insured Signature _____ Date _____