All INSURED PATIENTS

Virginia Dental Care (VDC) participates with the majority of major insurance companies. We do our best to obtain maximum benefits from your insurance company; however, payment for dental service is ultimately the patient's responsibility. We encourage our patients to verify coverage and benefits from their respective insurance companies.

INSURANCE VERIFICATION FORM

(Proof of insurance, SS#, and photo ID is required in order to verify and file to your insurance carrier)

Patient Name ………………………………………………………………… DOB ……………………………..

Responsible party if patient under 18: ………………………………………. DOB ……………………………..

Relationship to subscriber ……………………………………………………

Subscriber Name ………………………………………………………….... DOB ………………………..…..

Subscriber Social Security # ……-………-……….. Phone # ………………………………

Subscriber employer …………………………………………………..…. Occupation ………………………………...

Subscriber employer address …………………………………………………………………………………………

Insurance Co. full name ………………………………………………………………………………………………

Insurance Co. Address ……………………………………………………………………………………………...

Insurance Co. Phone # ………………… Group # …………………… Policy or ID# ……………………...

__IMPORTANT NOTICE__: **Please understand that VDC files dental insurance claims as a courtesy to our patients.** All claims are filed electronically to ensure immediate handling. As a participating dentist with your insurance company, we have accepted to comply with the negotiated fees. However, we do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles claims or what benefits they pay on a claim. We can only assist you in **estimating** your portion of the treatment cost if we are filing on your behalf. This portion is collected at the time of treatment. We cannot be held responsible for any errors made in filing your insurance that may have yielded an inappropriate treatment cost. In the event that a patient is overcharged, they will be reimbursed accordingly. **Once again, we file claims as a courtesy to you. If your insurance company rejects a claim, you will be responsible for the balance within 15 days of this rejection or 45 days post-treatment date.** In the event that an account becomes delinquent, VDC will apply a $10 administration fee and a 1.5% interest monthly interest rate to any balance owed.

I have read and understand the above terms and conditions above

Signature of Responsible Party …………………………………………… **Date** ……………………

Would you like to file your own insurance claims: YES☐ NO ☐

__Insurance Authorization Statement__ (Sign & Date, if you have chosen VDC to file on your behalf)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature of Responsible Party …………………………………………… **Date** …………………