HARRISON FAMILY DENTAL

Dental Insurance Information and Disclaimer

Please READ the following carefully before signing.
Please initial each section.

_____It is our pleasure to assist you with any insurance questions or problems you may have. We have knowledgeable staff who deal with insurance companies to see that your claims are processed quickly and accurately. Unfortunately, it is difficult to predict the benefits or restrictions your insurance company has in place. We will give you an estimate of your financial responsibility for any procedure before you are seen. **Please understand this is just an estimate.**

_____Upon your first visit, we will complete a comprehensive examination and have the necessary x-rays taken, usually a full mouth series of radiographs. If you have had x-rays at another dental office recently, we advise you to have them sent to our office prior to your appointment or bring them with you. If they are printed on paper we will need to make our own x-rays. The standard of care we use with regard to x-rays is bitewing x-rays every 6 months. We may or may not be able to "clean" your teeth at this initial examination. We will determine the type of cleaning your particular teeth need and reappoint for the appropriate length of time to treat your condition if necessary.

_____Please understand many dental plans have waiting periods, frequency limitations, and alternate benefits. These benefit are not considered when preparing a treatment plan. We will give you a comprehensive treatment plan with your best interest in mind, regardless of whether dental insurance may contribute. **You will be responsible for any difference in amounts your insurance does not pay.**

_____I have read the above insurance information and understand the possibility of certain services that may not be covered by my policy. I also understand and agree that an estimate of my cost, is just that, an estimate, and that there might be a balance left after insurance has received the claim and processed the payment. I also understand that insurance may not cover certain procedures at all, and in that case I am responsible for all charges.

_____I, the undersigned, do fully understand that Harrison Family Dental has agreed to file my insurance as a courtesy and that I am fully responsible for any treatment costs which are denied or not covered by my insurance company. I further agree that it is my responsibility to know the extent of my benefits, restrictions and limitations.

_____
Patient Signature or Parent of Minor