Implants Northwest
Dr. Daniel R.Cullum & Dr. Matthew M. Clark
Diplomates American Board of Oral and Maxillofacial Surgery

PLEASE READ AND INITIAL THIS ENTIRE FORM

As a courtesy to our patients, we bill Dental insurance for services at our office.

_____ Insurance is an agreement between you and your insurance company. Our Oral surgery office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. We DO NOT have access to negotiated and contracted fees specific to our group plan. Fees are established between the insurance carrier and the company or person purchasing the plan.

_____ PPOs (Preferred Provider Organizations) are like HMOs in that they have a network of dentists with whom they have a signed contract. Patients may choose a Surgeon on the PPO list or choose a Surgeon outside the "network". Because an "in network" PPO surgeon accepts a payment fee schedule, the patient's out of pocket expenses may be higher if you choose to go to a surgeon not associated with the particular network. An out of network surgeon is under no obligation to accept the PPO fees. The difference may be minimal or large.

_____ A pre-determination of benefits can be sent on your behalf and per your request prior to beginning treatment. Please note that it will take 4 weeks to receive a response from insurance that determines an estimated calculation of benefits.

_____ Estimated patient portion is collected in full the same day treatment is rendered.

It is important for you to have a copy of your policy and some understanding of it. This document is our attempt to avoid any financial misunderstandings. In the end you are responsible for anything your insurance company does not cover for any reason. Please complete the information below and present the most current Dental insurance card for this account. Failure to present accurate and current information may result in claim denial due to timely filing policies set by your insurance.

Policy Holder's Name _____ Policy holder's Date of Birth _____

Relationship to Patient _____ Social Security or ID Number _____

Claim Billing Address _____

Customer Service Phone Number _____Policy/Group Number_____

I have read, and understand the Implants Northwest Insurance/Financial policy.

Patients or representative signature _____ Date _____