Dental Insurance

1. Your dental insurance is a contract between you, your employer and the insurance company. *We are not a party to the contract*. As a courtesy, we will gladly file a claim with your insurance company on your behalf.

2. Our fees are considered to fall within the usual customary and reasonable ranges for most insurance companies. Please be aware that some companies pay according to an arbitrary fee schedule with bears no relationship to the current standard and cost of care in this area. Most insurance plans do not cover 100% of all procedure costs.

3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.

We are anxious to help you receive your maximum allowable benefits and our staff members are very knowledgeable with regard to the handling of your dental claim. Please provide us with a current dental insurance card containing the dental insurance company name, group number and a contact phone number. *Please note that insurance companies require a Social Security number to process any dental claim*.

Insured's Name_____Relationship to Patient_____
Address_____City_____State_____Zip_____
Home Phone_____Work Phone_____
Social Security No._____Date of Birth_____
Insurance Company_____Employer Name_____
Group Policy No._____Ins. Phone Number_____

If the patient has coverage under any; other insurance please list:

Insured's Name_____Relationship to Patient_____
Address_____City_____State_____Zip_____
Home Phone_____Work Phone_____
Social Security No._____Date of Birth_____
Insurance Company_____Employer Name_____
Group Policy No._____Ins. Phone Number_____

Assignment of Insurance Benefits

Patient's Name_____
Insured Name_____
Insured's Social Security No._____

I hereby instruct and direct_____
Insurance Company to pay by check made out and mailed to:

Howard Abrahams, D.D.S.
5685 Lake Placid Drive
Atlanta, Georgia 30342

If my current policy prohibits direct payment to the doctor, then I hereby instruct you to make the check out to me and mail it as follows:

Howard Abrahams, D.D.S.
5685 Lake Placid Drive
Atlanta, Georgia 30342

for professional, dental or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the professional services rendered. **This is a direct assignment of my rights and benefits under this policy.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, another dentist, or attorney involved in this case.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for all charges insured for any professional services rendered.

_____Date_____
(Signature of Insured)

_____Date_____
(Signature of Patient of other than Insured)