Advanced Dental Implant Solutions Office Policy

Please review the following policy statement.

Welcome to Advanced Dental Implant Solutions! Thank you for selecting our office for you and your family's dental needs. Prior to leaving our office today, you will receive a full explanation of your treatment plans and fees. If for any reason you did not understand any element explained to you, please do not hesitate to ask for clarification.

Payment Policy:

Accounts are payable after your insurance carrier has paid your claim, or within 30 days of your first statement. Self-pay patients will be asked to pay in full at the time of service. We accept all major credit cards, as well as debit cards with VISA OR MASTERCARD logo, cash or check. You will be financially responsible for any return check fees that ADIS incurs. If you have not paid your balance within 90 days your account may be frozen and referred to our collection department. In the event the payment cannot be made in full please call the office to discuss alternative payment plans. We will make every attempt to accommodate your situation. Initial: _____

Appointments:

Our office schedules appointments for the convenience of our patients' availability. We want our patients to have the best dental experience.

Appointment times are reserved exclusively for each of our patients and to avoid any fee for canceling an appointment we ask that you please notify our office 48 hours in advance of your scheduled appointment time. Quality care is first and foremost in our office. Emergencies do occur and we want to be able to help treat every patient, for that reason we do asked for your assistance. If we do not receive a call for a cancellation or failed to show as scheduled, you will be charged a broken appointment fee of **$50** per hour scheduled. Please be aware if you arrive 15 minutes after your scheduled appointment time, you may be required to reschedule your appointment. Initial: _____

Dental Insurance Policy:

We know that insurance can we quite confusing. Our office files dental insurance as a courtesy to our patients. We are out-of-network and our office does not accept Medicare, HMOs, or any supplemental insurances.

Out-of-network provider means that our office charges according to our office fee schedule, but the insurance company pays according to their own fee schedule. (EX: we charge $100 for a service and the insurance company says that they will cover 100% of that service; their allowable amount is $80; they will cover 100% of $80. The $20 difference will be the patient's responsibility). Initial: _____

Benefits Estimation:

If we are filing with your insurance, please keep in mind we make every effort to collect only the portion you owe at the time of service. However, this is an estimate and you may have a remaining portion or pay as a copay, co-insurance, or deductible. Your insurance plan will send you an "Explanation of Benefits" (EOB) which explain how your claim was processed. You will receive a statement of any balance you owe after we receive payment from your insurance. As a service to you, we endeavor to provide the most accurate information regarding any cost to you as our patient. However, these are estimations based on information available from your insurance carrier and subject to change given your insurance's final deliberation of this claim. It is your responsibility to verify the benefits you receive from your insurance in our facility. Should your insurance deny your claim for reasons beyond our control, you assume responsibility for payment for the claim. I have read and understand the above reference policy and benefits estimation. Initial: _____

6551 Harris Parkway Suite 250
Fort Worth TX 76132

Phone: 817-882-8282
info@advanceddentalimplantsolutions.com

Advanced Dental Implant Solutions Office Policy

Assignment of Benefits & Authorization to Pay:

Assignment of Benefits: I, the undersigned, hereby authorize ADIS to release any medical or other information necessary to process my claims for services rendered to me or my dependent. Initial: _____

Assignment to Pay: I, the undersigned, hereby authorize payment of dental benefits to the physician or supplier for services rendered to me or my dependent in connection with the treatment performed by ADIS. Initial: _____

By signing below, I hereby acknowledge that I have read, understand, and consent to all policies set forth herein.

Patient's Name:_____ Date of Birth: _____

Insurance Carrier: _____ Member ID: _____

Patient/Guardian Signature: _____ Date: _____

6551 Harris Parkway Suite 250
Fort Worth TX 76132

Phone: 817-882-8282
info@advanceddentalimplantsolutions.com