From the Office of Dr. Deborah A. Himelhoch, D.D.S., M.S., M.M.sc.

Your Child's Insurance Information

Primary Dental Insurance

Insurance Co Name: _________________________________ **Insurance Co Phone:** __________________

Insurance Co Address: ____

Group or Policy #: _______________ **ID #** ______________________________

Policy Owner's Name: ____________________ **Date of Birth:** ____________ **Policy Owner's Employer:** _____________

Employer's Address: ____

Orthodontic Coverage □ **Yes** □ **No**

Secondary Dental Insurance (if applicable)

Insurance Co Name: _________________________________ **Insurance Co Phone:** __________________

Insurance Co Address: ____

Group or Policy #: _______________ **ID #** ______________________________

Policy Owner's Name: ____________________ **Date of Birth:** ____________ **Policy Owner's Employer:** _____________

Employer's Address: ____

Orthodontic Coverage □ **Yes** □ **No**

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our treatment or recommended treatment, please do not hesitate to ask.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor. We would like you to understand that your insurance policy is a contract between you , your employer, and the insurance company. We will be happy to submit all forms for you and accept assignment of benefits. Occasionally, we will need your help with claim processing. All charges are your responsibility, whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies do not pay for certain dental services.

If you must cancel an appointment please try to give 48 hours notice. A fee will be charged for broken appointments.

1% interest will be charged on all accounts over 45 days.

Again, thank you for choosing us as your health care provider. We appreciate your trust and we appreciate the opportunity to serve you.

I understand that I am personally responsible for payment of all dental services rendered to me and /or members of my family regardless of whether I utilize my insurance coverage and/or credit card payment. By my signature here, I hereby agree to remain personally responsible for payment of all dental services rendered by Dr. Himelhoch and/or her staff to me and/or members of my family and I authorize and request the performance of dental services on the above named patient.

Patient/Parent's Signature_____________________________ **Date**___________________