

**Dr. James Lapierre DDS**

**40 North High St. Dublin, OH 43017**

**P: 614-889-1133 · F: 614-889-1147**

If you have dental insurance we are willing to work with you to see that you get the maximum benefits from your policy. We want to share with you information that will clarify the way dental insurance works.

 It is important that you understand that your insurance policy is a contract between you, your employer, and the insurance company.

 Most dental insurance companies cover a certain percentage of the fee for dental work needing to be completed, but there are companies that do not cover some procedures at all. Most policies have a yearly deductible and a maximum limit per family member. It is important to find out what portion of the treatment fee your particular policy will cover before we begin treatment. We can assist you with this**. Please note that any treatment plan and financial policy information given to you is just an estimate. We try our best to give you the most accurate insurance information. However, estimates are not a guarantee of final coverage.**

**Financial Agreement**

 I acknowledge and accept full responsibility for the payment of services provided and agree to pay for any treatment that is not covered by an insurance policy. The estimate portion is due at the time of service, unless specific payment arrangements are made with the office. In the event my insurance carrier pays less than the total fee charged for the services provided, I understand that I am responsible for the remaining unpaid balance.

 I understand that if I do not pay my bill within 30 days that a late fee will be added onto my final bill unless other arrangements are made with the office. If my bill is not paid within 90 days I understand that my information may be forwarded to a collection agency for payment.

 I understand and accept if I do no not have dental insurance that payment is due the time of service, unless otherwise discussed with the office.

 I authorize the release of any information required for the processing of dental claims. I authorize my insurance carrier to issue benefit payment directly to this office.

**SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**