MORRISON Dental Care
Lewis R. Morrison, DDS
David P. Morrison, DDS

# MORRISON DENTAL CARE
# INSURANCE PROTOCOLS AND INFORMATION

As a courtesy to our patients, our office will assist you in obtaining the maximum benefit from your insurance. We realize that understanding your insurance coverage can be challenging. Dental insurance pays based on the premium paid by you or your employer. Higher premium plans pay more of the fees for your dental care and have fewer exclusions. Dental insurance policies restrict payment for some services, use restricted fee schedules and exclude some procedures based on prior conditions, or length of time on the plan.

## Our courtesy service to you includes:

1. Filing your insurance claims by following the American Dental Association guidelines for coding procedures. This includes electronic filing for faster turn around, and requesting payment of your benefit to our office.
2. *ESTIMATING* your dental benefits based on available information or general reimbursement guidelines. Estimates are not guaranteed and are subject to any number of factors including the stipulations of your employer's plan and your annual dental maximum.
3. Calling your insurance company if we have not been paid within 30 days.

## Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan at the time the service is rendered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Taking responsibility for payment if the insurance company does not pay our office within 45 days.
4. Keeping our office informed of any changes in your insurance coverage, either by phone or in person, <u>before</u> your next scheduled appointment.

To assist us in obtaining your benefits, **please sign the "assignment of benefits" below** to allow us to file your insurance claims. Also, please have your insurance card ready for us to copy for your file.

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Name of Primary Insured: _____ SS#: _____ Relationship to Pt: Self Spouse Child
(Last First MI)

Insurance Plan Name and Address: _____

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Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Employer Name: _____

Name of Secondary Insured: _____ SS#: _____ Relationship to Pt: Self Spouse Child
(Last First MI)

Insurance Plan Name and Address: _____

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Insured's Birth Date: _____ ID #: _____ Group #:_____

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**I hereby authorize Dr. Lewis Morrison/Dr. David Morrison to release to my insurance company any information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Morrison. I understand that I am responsible for any unpaid balance.**

_____ _____
SIGNATURE OF PATIENT/INSURED DATE

06/29/15