McGee Family Dentistry

ASSIGNMENT OF INSURANCE BENEFITS

It is important to understand that the insurance contract is between the insurance company and you, the insured. Our office will gladly submit your primary insurance claim to your insurance carrier, as a courtesy to you.

Please understand that we are only given an estimate for your dental care therefore we can only pass the estimation on to you, the patient. At the time of treatment, the patient/guarantor is responsible for the portion that we estimate your insurance does not cover, based on the percentage of coverage for your individual plan. If your insurance carrier has denied or not made payment within 30 days, the patient/guarantor is responsible for the balance in full.

Due to pending claims and patient privacy issues, we do not always know how much an insurance company has already paid to another office or specialist and the balance remaining on a yearly maximum.
After your insurance pays their portion there may still be an amount due. This amount will be your responsibility and will be due within 30 days after receipt of insurance payment or prior to your next scheduled appointment, whichever comes first.

Dental insurance was not designed to pay for all dental care. Our goal is to maximize the amount of your care covered by your insurance benefits. However, it is important to understand that treatment recommendations made by the dentists at our office are based on an individual's needs, and not necessarily based on what insurance coverage is available. Please be prepared to show your current insurance card & driver's license at the time of your visit.

IN ORDER FOR US TO PROCESS YOUR INSURANCE CLAIMS, WE WILL NEED YOUR SIGNATURE TO RELEASE PAYMENT.

I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID BY DENTAL BENEFIT PLAN, UNLESS THE DENTIST HAS A CONTRACTUAL AGREEMENT WITH THE PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO ANY CLAIM FOR SERVICES RENDERED TO ME OR TO MY DEPENDANTS.

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO
DR. DONALD R. MCGEE, DMD PA.

_____

PATIENT'S NAME (PLEASE PRINT)

_____ _____

AUTHORIZED SIGNATURE (PARENT/GUARDIAN IF PATIENT IS UNDER 18 YRS) DATE

_____

RELATIONSHIP OF PATIENT & AUTHORIZED SIGNER