Pine Ridge Dental
*5140 S. 56th St. Lincoln, NE 68516 *8545 Executive Woods Dr. Lincoln, NE 68512*
*Phone: 402.423.1100 * Fax: 402.423.1368 * www.pineridgedental.com*

Insurance, Financial Options, and Appointment Agreement

Patient Name:	Date of Birth:

Dental Insurance

As a courtesy, we will process your insurance benefits for you. All questions regarding your insurance coverage must be addressed by you with your insurance carrier. We will provide you with a treatment plan that lists dental codes, procedures and fees so that you can call your insurance carrier for estimates. Insurance companies never guarantee benefits. We will estimate your copay as closely as possible, and anything they do not pay is your responsibility. **I understand that my estimated portion that is not covered by my insurance is due at the time services are provided.** _____ (Initial)

Primary Insurance Coverage

Policy Holder: _____

Employer: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Phone: _____ Group #: _____

Policy Holder ID#: _____ Date of Birth: _____

Secondary Insurance Coverage

Policy Holder: _____

Employer: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Phone: _____ Group #: _____

Policy Holder ID#: _____ Date of Birth: _____

Financial Options

We are committed to supporting you in understanding your dental health, and will always present you with the best dental options possible to address your personal health situation. To make these services comfortably affordable, we are pleased to offer you the following patient options:

1. 5% Courtesy fee reduction for pre-payment in full for services paid by cash or check
2. Cash, Check
3. Visa, MasterCard, Discover
4. No interest payment plans with *CareCredit* up to 12 months

I agree that I am fully responsible for the total amount of all procedures performed at Pine Ridge Dental, including all dental care that is not a covered benefit by my dental carrier. I understand that all services are due within 60 days of the date of service, regardless of whether or not my insurance has paid. I understand that at 60 days my account will accrue interest of 1.3% per month (not more than 16% annually) and balances over 90 days are subject to collection activity. _____ (Initial)

Appointment Agreement

We value your time and reserve a set amount of time in our schedule to ensure you receive quality care. Should you need to cancel or change your appointment, **we ask for a 24-hour notice. Otherwise, you could be subject to a $35 broken appointment fee.** Our goal is that you have an outstanding experience at Pine Ridge Dental. If you have additional questions, please speak to one of our administrative team members for further information.

_____ _____

Patient / Parent / Legal Guardian Signature Date