Insurance and Payment Explanation

Stones Family Dental appreciates having you as a patient and we would like to explain the "ins & outs" of insurance as we understand them. It is our attempt to communicate how insurance benefits are paid, and in so doing, we hope to eliminate misunderstandings that otherwise could occur.

Insurance can be confusing with terms such as co-payments, deductibles and percentages. We hope that this sample information will help clarify our potential responsibility and your potential responsibility.

Most dental carriers cover a percentage of your total cost for dental services. Insurance companies will pay the percentage of their own determined cost for a procedure. Insurance Policies refer to this as "Usual Customary and Reasonable" (UCR). Keep in mind this is the amount the insurance company has determined to be the coverage allowed expense.

The other method of determining "allowable benefits" is by paying benefits according to a "fee schedule." 100% of the fee listed in the policy (which often is different than our office's fees) for a given procedure is paid. If your plan benefits are based on a fee schedule you will have a copy of allowable fees in your benefits brochure provided by your Employer or Insurance Carrier.

Example

Service: Adult Prophy (cleaning the teeth) = $1O5.OO (example)
Insurance company determined "UCR" rate = $95.OO
Your plan benefit is 8O% of the "UCR" rate =$76.OO
Your responsibility at the time of service is the cost ($1O5.OO) minus what is reimbursed by your insurance company ($76.OO); your balance to pay is the difference of $29.OO
At the time of service we "estimate" the difference in the cost between your anticipated benefit and our fee; this is what you are asked to pay the day of service.

In the event the insurance company's actual benefit paid does not pay the services in full, you will be responsible for any unpaid amount. Past due accounts over 90 days will be assessed a late charge of l .5% per month on any outstanding balances.

If you have any questions or need further explanation, please ask us and we will be happy to provide more detail.

X _____ _____ _____

Patient Name (Print) *Patient Signature* *Date*