RIVER'S EDGE ORTHODONTICS

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DENTAL INSURANCE INFORMATION AND ACKNOWLEDGEMENT

PLEASE PROVIDE YOUR DENTAL INSURANCE CARD AT THE INITIAL VISIT.

WE WILL SUBMIT INSURANCE CLAIMS FOR ALL PROCEDURES AND THE INSURANCE BENEFITS WILL GO DIRECTLY TO POLICY HOLDER.

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's SSN: _____

IF NO INSURANCE CARD IS AVAILABLE, PLEASE PROVIDE:

Name of Insurance Company: _____

Address of Insurance Company: _____

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Phone Number of Insurance Company: _____

Acknowledgements

INSURANCE DISCLAIMER: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's insurance contract at the time of service.

ASSIGNMENT OF BENEFITS: I agree to be responsible for all charges for dental services and materials. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with dental/orthodontic claims.

BENEFICIARY AGREEMENT: I understand that my dental insurance company may deny payment for services. I also understand that, if my dental insurance company does not make payment for services to the subscriber, I will be responsible for any outstanding balance due to the provider.

_____
Signature of Patient or Parent/Guardian

_____
Date