**Insurance Disclaimer**

**(Please read carefully)**

**This office does not participate with any insurance plans, Medicaid/care or discount plans.**

Our goal is to assist you in maximizing your dental insurance benefits. As a courtesy, we will be happy to submit your dental insurance claim on your behalf and your insurance company will reimburse you directly. Please remember that the contract itemizing your dental benefits is between you, your employer, and your dental insurance company.

Any treatment plan that our office proposes to you is an **estimate** of what your insurance coverage will be, it is not a guarantee. If you need **exact** payment of benefits, then a pretreatment estimate is required. You must specify this to our team prior to initiating treatment. (This process could take 4-6 weeks time.) Please also keep in mind that it is not uncommon for insurance companies to claim that a procedure is covered at time of pre-determination, to later deny that claim when submitted.

Regardless of your coverage, your payment is due in full on the day of the treatment.

Your dental insurance does not send your Explanation of Benefits to our office. Therefore, we do not know if and when your insurance company reimbursed you. If you have not received your payment from them in 4-6 weeks, you will need to contact your insurance company. If a claim needs to be resubmitted you may call the office and we will be happy to resubmit for you.

**Dental insurance plans are not designed to cover all of your dental needs.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have chosen to allow Stacie L. Dietz, DDS to file my insurance claim. I also accept full responsibility for this account or all dentistry performed upon myself and my family in this dental office. I understand that it is my responsibility to be aware of the type of dental plan I have. I also understand that this office cannot guarantee my insurance company will cover all services rendered.

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**