Utah Periodontal Specialists
Financial Questionnaire

Date _____

Person Responsible for Account

Name _____
Last First

Relationship to patient _____Birthdate _____/_____/_____

Phone number(s) Home: _____Work: _____ Cell: _____

Billing Address _____

Employer:_____

Dental Insurance

Primary Dental Insurance

Insurance Company Name _____

Insurance Company Address _____

_____

Insurance Company Phone _____

Subscriber ID# _____ SS# (If applicable)_____

Subscribers Name _____ Relationship to patient _____

Subscriber's Birthdate _____/_____/_____

Employer _____

Secondary Dental Insurance

Insurance Company Name _____

Insurance Company Address _____

_____

Insurance Company Phone _____

Subscriber ID # _____

Subscriber's Name _____ Relationship to patient _____

Subscriber's Birthdate_____/_____/_____ SS# (If applicable)_____

Employer _____

Parent/Spouse Information

Name _____
Last First

Birth-date _____/_____/_____ SS# _____ DL# _____

Phone number(s) Home: _____Work: _____ Cell: _____

Employer _____

AGREEMENT TO PAY / FINANCIAL ACKNOWLDEDGEMENT

Please be prepared to pay your **estimated portion** at the time of service regardless of insurance coverage.
Please be prepared to show evidence of insurance coverage (if applicable) and Picture ID at all appointments.

1. Professional services are rendered to the patient, and not the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.

2. Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows.

3. **For your convenience we will ESTIMATE the portion of your total fee that your insurance company will cover. This is JUST AN ESTIMATE. After insurance benefits, you are responsible for ANY UNPAID BALANCE. We will ask you to bring with you at the time of surgery the ESTIMATED uncovered portion of the total fee.**

4. A finance charge of 1-1/2% per month will be added your bill if payment has not been received within 60 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction.

5. Should collection become necessary, the responsible party agrees to pay additional collection fees, returned check fees, and all legal fees of collection, with or without suit, including attorney fees and court costs. I also authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. **I hereby authorize release of information for insurance purposes.**

Thank you for your understanding in this matter.

Signature: _____ Date: _____
(Patient, Legal Guardian or Authorized Agent of Patient)

Witness: _____ Date: _____