**ANDERSON & SLACK & ASSOCIATES**
720 West Corbett Avenue
Swansboro, NC 28684
(910) 326-3611 FAX (910) 326-1122

Patient's Name _____ Email: _____
Last First Middle

Date of Birth _____ Age _____ SSN _____ ( ) single ( ) married ( ) widowed

Name of Spouse (if applicable) _____

Parent Names (if applicable) _____

Home Address _____
Street/PO Box City State Zip

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Name of Employer _____ Work Phone (____) _____ - _____

## DENTAL INSURANCE

*Primary Insurance*

Insured Name: _____ SS# _____ Date of Birth _____

Insured's Employer Name: _____ Insurance Plan Name _____ Group # _____

Customer Service Telephone: _____ Patient's relationship to insured: _____

*Secondary Insurance*

Insured Name: _____ SS# _____ Date of Birth _____

Insured's Employer Name: _____ Insurance Plan Name _____ Group # _____

Customer Service Telephone: _____ Patient's relationship to insured: _____

## Financial Information for our Patients

- As a courtesy to our patients, our office will assist you in obtaining the maximum benefit from your insurance.
- Payment Policy: Our office is a fee for service office, meaning we politely ask you for payment **in full** at the time services are rendered. For your convenience, we accept most Dental Benefits, Cash, Check, Visa, Mastercard, Discover Card, American Express and Care Credit.
- We charge $30 returned check fee and a $30 collection fee for accounts sent to our outside collection agency.
- Our courtesy service to you includes electronically filing your insurance within 24 hours of your appointment so benefits may be paid directly to our office by following the American Dental Association guidelines for coding and filing insurance claims.
- Our expectation of you as the owner of the policy is to make payment in full of fees or co-payments not covered by your insurance plan at the time services are rendered. We also ask that you understand that the policy belongs to you and we have no leverage to obtain payment from your insurance. With that, we ask you to take responsibility for payment of your visit should your insurance company not pay within 45 days. A service charge of 1.5% will be added to all accounts 30 days past due (EXCLUDING PENDING INSURANCE for 45 days). In order to avoid this situation, we ask that you keep our office informed of any changes in your insurance coverage or employment.
- Every dental insurance policy has a maximum benefit, which we are able to track for services rendered in our office. If you have received care by another office, we cannot be responsible for calculating your remaining benefits accurately. You may call your insurance company to receive an updated amount after services have been paid to all office(s) involved.
- On the date of your office visit, you are responsible for your deductible and the portion we estimate the insurance will not cover. However, if our estimates are inaccurate, there will be a need to send you a receipt for the balance due.

I hereby authorize benefits to be paid directly to Anderson & Slack. I understand I am responsible for any unpaid balances or dental services not paid by my dental benefit plan. I have read and agree to this Financial Policy.

_____

**Signature of Patient or Responsible Party** **Today's Date**