Aspen Dental Care

Patient Insurance Assignment of Benefits Policy (direct billing)

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Please disregard if you do NOT have dental benefits

Your individual dental policy may or **may not cover** the full amount of the cost of your dental claims for your treatment. This can occur for many reasons such as but not limited to **difference in fees***, insurance maximums, frequencies and limitations set by your insurance provider. In addition, there may be certain procedures that are not covered by your individual policy.

Aspen Dental Care is happy to accept direct payment from your insurance for any dental services covered by your policy. However due to the numerous and varied dental plans available it is near impossible for us to know all the details (etc. limits, frequencies and maximums) for each individual insurance policy. **In addition, due to privacy laws, dental providers are very limited, or even exempt, from receiving detailed information pertaining to your dental policy.**

For the reasons above we ask that you **fully understand** that your insurance policy is *a contract between yourself and your insurance company*. Aspen Dental Care does provide the option of submitting an estimate for your proposed treatment to your insurance provider prior to your appointment (2-6wks) UPON REQUEST. **An estimate will not be sent unless you have requested one.** It is possible that during the course of treatment other procedures may be identified that may dictate additional procedures or fees. Rest assured, you will be advised of any changes to your treatment. However to receive an estimate response from your insurance company it can take anywhere from 2-6 weeks.

It is important to understand that **the dentist's and hygienist's recommendations are based on your specific dental needs and not on your dental coverage**. We cannot provide dental recommendations under the assumption that your insurance will cover all the proposed treatment. FULL payment to our office remains your responsibility regardless of how much your insurance does or does not pay.

Due to these factors, if you require Aspen Dental Care to directly bill your insurance company **we require a copy of your credit card on file**. Once treatment is delivered we immediately submit the claim to your insurance. In instances where the insurance provider does not immediately inform us of the amount that they covered we have to wait 1-4 weeks to receive payment. **Once payment is received we will automatically charge your credit card the amount owing.**

* **Difference in fees**: Although your insurance covers a certain percentage of your dental claim it does NOT mean they will be paying according to our fee schedule. The Alberta Dental Association does not have a set fee guide and some insurance plans continue to pay according to the outdated fee schedule which dates back to 1997.The Alberta Dental Association advises that each dental office determines their fees according their own discretion; therefore fees vary from office to office.

The example used below is taken from a patient's claim under Alberta Blue Cross' personal plan (Policy# 2007/2008/2009) which uses an outdated fee guide.

Procedure	Description	Th# Date.	Charge	Eligible	Deduct	AT	Benefit	
01202	Recall	Jul/09/13	66.00	49.20	0.00	100%	49.20	1
02601	Panoramic Film	Jul/09/13	85.00	70.20	0.00	80%	56.16	2
11112	Scaling Two Units	Jul/09/13	130.00	99.60	0.00	100%	99.60	3

TOTAL PROVIDER CHARGES: 281.00
TOTAL PAYABLE TO Provider: $ 204.96

Charge= Aspen Dental Care office fee guide
Eligible= Insurance fee guide

As shown above, the recall exam has a fee of $66.00; although the patient's coverage indicates 100%, the insurance has only paid $49.20 (Eligible), leaving an out of pocket expense of $16.80. Please note, each insurance policy has a different fee guide, and we will not be able to determine which fee guide your plan uses.

We will accept direct insurance payment for covered services under the following conditions:

Please initial beside each condition once you have read and understand.

1) I am aware that Aspen Dental Care directly bills to my insurance company as a courtesy to me and that in doing so, the dental office accepts **no responsibility** for any uncovered amounts, amounts over benefit maximums, plan limitations or restrictions, ect. I understand that Aspen Dental Care collects information from my dental insurances as a guide only, to assist me in maximizing my dental benefits. This does NOT hold them accountable for my dental account. Aspen Dental Care advises that I make myself **very aware of my dental plan**, knowing my coverage details including frequencies, limitations as well as keeping track of my yearly maximum**. INITIAL**_____

2) I consent to leave a credit card #on file at Aspen Dental Care. If Aspen Dental care does not receive a confirmation from my insurance of their exact payment on the date of service, Aspen Dental Care will AUTOMATICALLY process the co-payment once my insurance has made payment to them (approx. 1-4wks) after delivery of treatment. **INITIAL**_____

3) I also understand that any uncovered procedures completed by another dental office are my responsibility. Certain procedures are only covered once per specified time period. For example a new patient exam, which is billed when you visit an office for the first time, *may* only be covered once every 3-5 years. If you have had a new patient exam billed at another office in that time period you will be responsible for that fee. I am aware that if procedures are not covered the full amount will be charged to my account. I agree to pay these procedures should they not be covered by my insurance. **INITIAL**_____

4) I understand that for any major treatment, Aspen Dental Care requires a copy of the pre-determination approval from my insurance company prior to commencing treatment if I wish for these procedures to be directly billed. If I decide to proceed with major treatment without a pre-determination I will pay upfront for my treatment and Aspen Dental Care will submit my claim on my behalf. **INITIAL**_____

My signature below confirms that I have read and understand the above information. By signing this document I am taking full responsibility of my account and understand it is my sole responsibility to be familiar with the details of my plan.

NAME: _____ SIGNATURE: _____

DATE: _____

****PLEASE PRESENT YOUR CREDIT CARD WITH THIS SIGNED POLICY FORM. A COPY OF YOUR CREDIT CARD WILL BE KEPT ON FILE.**

IF YOUR CREDIT CARD INFORMATION CHANGES PLEASE ADVISE US IMMEDIATELY TO PREVENT A NSF CHARGE FOR DECLINED PAYMENTS