Barry P. Setzer, D.D.S.
Stephen D. Cochran, D.M.D.

Flavio M. Soares, D.D.S.
Karen A. Hubbard, D.D.S.

INSURANCE VERIFICATION

PATIENT NAME:

INSURANCE COMPANY NAME:

Insured's Name:	Relation to Patient:
Group Number:	Insured's Policy ID Number:
Insured's Date of Birth:	Insurance Company Phone:
Insured's SSN:	Insured's Employer:

Insured's Billing Address:

SECONDARY INSURANCE:

Insured's Name:	Relation to Patient:
Group Number:	Insured's Policy ID Number:
Insured's Date of Birth:	Insurance Company Phone:
Insured's SSN:	Insured's Employer:

Insured's Billing Address:

OUR FINANCIAL POLICY AND HOW IT WORKS FOR YOU

Whether you are paying with cash or using insurance, you are always ultimately responsible for your bill. We expect payment at the time of service, so please make arrangements to pay when you arrive for your appointments.

OUR RESPONSIBILITIES

- We will verify your insurance benefits.
- We will bill your insurance for you as a courtesy.
- We will correct any errors we have made when there is a billing dispute.
- We will provide guidance in getting your bills paid.

YOUR RESPONSIBILITIES

- Please know and understand your insurance coverage.
- Please pay your deductible, coinsurance or copayment at the time of your treatment.
- Please read and keep your Explanations of Benefits statements from your insurance.
- Please follow up promptly with claims that are not paid by your insurance company, or you will be billed directly for them.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of the above provided information and any medical information necessary to: 1) provide for adequate professional coverage in the absence of the primary doctor; 2) to verify insurance coverage; and 3) to file a claim for insurance benefits related to professional services rendered.

Patient Name ______________________________

Signature (Parent or Responsible Party)______________________________ Date __________

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

I authorize direct payment of insurance benefits from ______________________ to Pediatric Dentistry for professional services rendered. (Insurance Company)

Signature (Parent/Responsible Party) ______________________________ Date __________