DUFFINS CREEK DENTAL
PATIENT INSURANCE RESPONSIBILITY

This office will provide direct insurance billing services for you, if you so desire, as a courtesy. **Remember that you are ultimately responsible for any charges incurred at this office. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance provider. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.**

The treatment recommended by our office is never based on what your insurance company will pay. We encourage you to proceed with necessary treatment regardless of your insurance benefit. Oral health should never be ignored because of insurance restrictions. It is the patient's responsibility to know their contracts have time limits, exclusions, annual benefit maximums, and/or various degrees of co-payment. Please take the time to review your contract thoroughly so we may best serve you.

By law, a claim made to an insurance company must be an accurate description of services rendered and fees charged. We cannot change the date of service, treatment code, fee or patient name on an insurance claim.

It is against the law (insurance fraud) for you or your dentist to conspire to avoid paying the co-payment. Not only is it a violation of the law, but it is contrary to the regulations of the Royal College of Dental Surgeons of Ontario (RCDSO) that regulates the dental profession. This constitutes professional misconduct and a dentist can loose their license, as well as incurring hefty fines, often exceeding $10,000.

When needed, we will do our best to assist with your dental claim or predetermination. We are considered "third party" and not often allowed access to information or the freedom to discuss a claim. The Privacy Act considers dental care and fees/insurance claims to be personal and confidential. We are happy to help when permitted.

If you are the custodial parent/guardian of a child or dependant adult you are responsible for dental expenses originating from this office.

Responsible Party (if patient is a child/dependent adult)

Name:_____ DOB:_____
(Last Name) (First Name) (Initial) DD/MM/YYYY

Address:_____
(Street) (Apt #) (City) (Province) (Postal Code)

Phone:Home:_____ Cell:_____ Work:_____

We hope this information has been helpful. As always, feel free to ask our patient services team for clarification on services and account finances.

I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signed:_____ Dated:_____