DUFFINS CREEK DENTAL

596 Kingston Road West Ajax ON L1T 3A2
Tel. (905) 683-2561 Fax. (905) 683-2570
Email: info@duffinscreekdental.com

PATIENT INSURANCE RESPONSIBILITY

This office will provide direct insurance billing services either via EDI (Electronic Data Interchange) or mail, for you, with your permission, 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. We hold no responsibility for checking your insurance coverage. Please do so prior to your appointment. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.**

The treatment recommended 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.

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 dentists 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 lose their license, as well as incur hefty fines, often exceeding $10,000.

When needed, we will do our best to assist you 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, fees and insurance claims to be personal and confidential. We are happy to help when permitted.

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

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

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

We hope that 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: _____ Date: _____