ROSEWOOD DENTAL
Joseph C Johnson DDS
Landon B Rockwell DDS
181 West Vine Street
Tooele UT 84074
435-882-0099

Patient Name: _____

Insurance Co.
Primary: _____

Secondary: _____

THE FACTS ABOUT INSURANCE

Please understand we are desirous to extend care to you and to work with you and any insurance coverage you may have.

1. Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.

2. Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows.

3. For your convenience we will ESTIMATE the portion of your total fee that your insurance company will cover. This is JUST AN ESTIMATE. After insurance benefits, you are responsible for ANY UNPAID BALANCE. We will ask you to bring with you at the time of treatment the ESTIMATED uncovered portion of the total fee.

4. If you desire to know exactly what your insurance coverage will be, prior to treatment, then we can pre-determine or pre-authorize your benefits. However, this delays treatment 4-6 weeks, waiting for the insurance company to respond.

5. A finance charge of 1 ½% per month will be added to your bill if payment has not been received with 60 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction.

6. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I also authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. I hereby authorize release of information for insurance purposes.

Thank you for you understanding in this matter.

_____ _____
Patient or Responsible Party Date