Payment and Insurance Policy

As many of our patients have some form of dental benefits, we are happy to complete the treatment portion of the dental insurance form and submit them to your insurance company at no charge to you. You are directly responsible for the payment of any outstanding balance.

Your “patient portion” and payment for services not covered by the plan are expected to be paid in full at the time the service is rendered. Treatment plans decided between you and the dentist are based on your dental needs, it cannot be assumed that the insurance company will pay for all recommended treatment charges.

It is important for patients to understand prior to treatment the limitations of their own coverage and take responsibility for their portion of the bill not covered by insurance. We aim to provide excellent quality care individualized to your specific dental needs.

Please note: some procedures that you may really need may not be covered by your plan. We will help you make the most of your insurance benefits and we will try to make your portion affordable to your budget. We treat you - the patient - and not your dental plan.

Please remember that your plan is negotiated between your employer and the insurance company, not the dentist, and there are hundreds of different plans. Most dental benefit plans that indicate 100% coverage will in fact not cover all fees of our current practice fee guide. As a result, we are often not privy to know the details of your plan including coverage and yearly maximums.

Let us help you by bringing an actual copy of the plan on your first visit. We will gladly interpret policy booklets and handle any written pre-determinations as a complimentary service to you. To avoid errors, let us know of any changes with your plan or coverage.

We provide written estimates for various treatment options. Our office has an advanced computerized system to file insurance claims electronically.

To give you flexibility and reduce estimates processing costs and inaccuracies, our office offers three methods of payment:

- **Pay As You Go:**

The most simple and efficient selection. All treatment is paid for at the time of service and your dental insurance company will reimburse you directly. (For your convenience, we accept cash, cheque, Visa, Mastercard, and Interac - this solution is great for people wanting to accumulate Airmiles® or Points.)

- **Continuous Authorization:**

Our office will collect from your dental insurance company and charge any outstanding balance to a Major Credit Card. (pre-authorization required - see below.)

- **Pre-Payment Plan:**

Anticipate the planned work ahead of time. You may pre-pay as you like prior to treatment on your own schedule as your budget allows.

Our business team would be pleased to answer any questions you may have regarding fees, insurance, and financial arrangements. Please ask us! We are here to help you.

Please select your payment method of choice *(check one):*

☐ **Pay As You Go:**

Time to Care Dental Group will complete the treatment portion of my dental insurance form and submit them to my insurance company (if applicable). I will pay all treatment at the time of service and my dental insurance company will reimburse me directly.

☐ **Continuous Authorization:**

Time to Care Dental Group will complete the treatment portion of my dental insurance form, submit them to my insurance company and collect payment from my dental insurance company. I hereby authorize Time to Care Dental Group to charge my portion and payment for services not covered by the plan at the time the service is rendered as well as charge any and all outstanding amounts once the actual payment arrives from the insurance company to the following Credit Card:

Name: _____

Card Number: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Amex

Expiry Date: _____/_____
Year Month

CVC/D: _____

☐ **Pre-Payment Plan:**

Time to Care Dental Group will keep funds on my behalf to pay for dental treatments. All funds are refundable at any time within 5 days written notice. Receipts will be given for all deposit payments and monthly balance statements will be mailed out.

A. I _____ *(print name)* understand and accept the Financial Policy and Payment Method I selected above;

B. Should my insurance company not reimburse part or all treatment fees, I agree to the FINANCIAL RESPONSIBILITY for the total fee.

Signature: _____

Date: _____