OSHINS OF SMILES
Advanced Dentistry for Total Body Wellness

Oshins of Smiles Financial Policy

Our office is committed to providing you with the best possible dental care. If you have dental insurance, we are happy to you help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly answer any questions relating to your insurance. Your insurance is a contract between you, your employer, and your insurance company. Not all services are covered benefits in all contracts. There are some procedures insurance companies do not cover. Insurance companies rarely reimburse the full amount of restorations, or major procedures. Generally they pay 50% to 80% of the fee.

We are happy to file all insurance claims for you. Our filing the claim on your behalf does not guarantee payment nor does a pre-determination of benefits represent a guarantee of payment. Our office will estimate what your portion will be based on information we have available to us, any balance is expected in full at time of service. Some insurance companies pay the patient directly and in turn we ask that you pay the entire amount at time of service. Any balance not paid by the insurance company is solely your responsibility.

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. While the filing of insurance claims for dental charges is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered.

Any account with an outstanding balance that has not been paid in full within 90 days will be considered delinquent and will be referred to an outside agency for collection. If an account is sent to this agency, the patient or patient's guarantor will bear the responsibility of any fees involved in collection on that account.

If you have any questions about the above information, please don't hesitate to ask us.

Signature

Date *

_____

Month   Day   Year

Patient Name *

First Name   Middle Name   Last Name