Indian Valley Dental Associates *Marc F. Lipkin, D.M.D., F.A.G.D*

601 East Broad Street Ste 200
Souderton, PA 18964
215-723-5531

Preventive Dentistry for Adults and Children
Dental Implants, Prosthodontics and Cosmetics

Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, Discover, and have six months interest-free financing through American General Financial. We will be happy to process your insurance claim form for you, if you provide us with all necessary information. If we are not informed of insurance changes please be aware that the patient may become responsible for payment of visit.

We respect the importance of your time and work very hard to schedule appointments which accommodate the busy scheduling needs of all of our patients. In return, we ask that patients make every effort not to change scheduled dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice. Accordingly, appointments cancelled with less than 24 hours notice are subject to a cancellation charge. Checks returned by your bank are subject to a$25.00 processing charge. Accounts unpaid after 30 days from the date of billing are subject to a finance charge of 18% apr. If your account is referred for collection, you will be responsible for any collection costs as well as any court costs and reasonable attorney's fees.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.
You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most, but not all, companies.*

**This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.*

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is the responsibility of the insured and covered parties to understand their insurance policy as you are the covered individual.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems do arise and we encourage you to contact us promptly for assistance in the management of your account, if necessary.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

OVER

Patient Information Form

Name_______________________________

Home Address____ Phone #__________

Spouse's Name (If applicable)_________________________ Work Phone#________________________

Nearest relative not living with you____________________ Phone#___________

Whom may we contact in the case of an emergency?

____ Phone___________________

I understand that all radiographs taken for diagnostic and/or insurance purposes as well as all records are the property of this office and any duplication necessary for any other purpose may require an additional fee.

I understand and agree that (regardless of my insurance status) I am responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Who is financially responsible for this bill? (If other than patient)____________________________

____

Signature (Parent if minor) Date

DENTAL INSURANCE INFORMATION:

Name of Insured:_______________________ Insured's Date of Birth__________

Social Security# of Insured:_____/_____/______

Name of Insurance Company & Address:

_______________________________ Group#__________

_______________________________ ID#___________

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Employer:__________________________ Address____________________ Phone #________________

SECONDARY INSURANCE INFORMATION:

Name of Insured:_______________________ Insured's Date of Birth__________

Social Security# of Secondary Insured:_____/_____/______

Name of Insurance Company & Address:

_______________________________ Group#__________

_______________________________ ID#___________

____

Employer__________________________ Address____________________ Phone #____________________