

EXPLANATION OF DENTAL INSURANCE AND DENTAL PLANS

Claudio Iwamoto DDS MS • 19450 Deerfield Avenue Suite 270 • Lansdowne, VA 20176 • 703-858-3838

We are pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits, so with this in mind, please read the information regarding our policy on dental insurance benefits.

DO YOU ACCEPT MY INSURANCE?

If your insurance plan allows you the freedom to choose your own doctor, then you can use your benefits in our office. We are happy to file your claim for you, and will accept the assignment of benefits if your plan allows. Accepting assignment of benefits does not mean that we accept whatever the insurance company pays as full payment. Most insurance plans require the patient to pay a deductible and a portion of the bill.

HOW MUCH WILL THEY PAY?

Once we have the opportunity to verify your dental insurance coverage and obtain an approximate breakdown of benefits, we are able to estimate your payment portion based on the information we receive, but it is **ONLY AN ESTIMATE**. Please understand that we do not have a contract with any insurance company (with the exception of some PPO insurances); therefore it is impossible to give you a guarantee of what the insurance company will pay at the time of service. **If we are unable to verify your insurance coverage, you are responsible for payment in full of all fees associated with your treatment at each visit.**

If you want to determine what your insurance will pay, we are happy to file a pre-treatment authorization with your insurance company prior to treatment. This may take up to several months, but will give you the exact out of pocket figure you require.

INSURANCE DIDN'T PAY NOW WHAT?

Ultimately, you are responsible for all charges incurred in our office. We file your primary insurance claim as a courtesy to you. We do not file for secondary insurance. Some procedures performed in our office *may* be covered by your medical insurance; we do not file this for you. We will provide you with an itemized statement of procedures performed. It is important that you recognize the insurance you have is a legal contract between YOU and YOUR insurance company. Our office is not, and cannot be a part of that legal contract. If your insurance company does not pay a claim within 60 days, Claudio Iwamoto DDS MS reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. Additionally, dental insurance is designed to defray the cost of your dental treatment. It is not intended as a total payment for services and should not be used to determine the type of amount of treatment you receive.

I THOUGHT I PAID MY PORTION BUT I STILL OWE MORE, WHY?

We base your estimated out of pocket expense on the benefit verification information we receive from your insurance company, but there many factors that can affect this estimate. There may be an annual deductible that must be met (individual or family), or you may have received treatment in another office. Further, insurance companies do not (and cannot in most cases) notify our practice of changes to your benefits, they only notify you. If any of these situations apply to you, please let us know as soon as possible.

WHAT IS UCR?

UCR stands for Usual, Customary, and Reasonable. It is a term created by insurance companies to define what they are willing to pay for a particular procedure.

ASSIGNMENT OF BENEFITS

I authorize my insurance company to pay the office of Dr. Iwamoto all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance claim submissions.

I authorize the office of Dr. Iwamoto to release all information necessary to secure payment of insurance benefits.

I understand that I am financially responsible for all fees regardless of whether or not they are covered by insurance.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment.

Patient/Parent/Guardian Signature _____ Date _____

Please ask if you would like a copy of this form.