OASECT
ORTHODONTIC ASSOCIATES OF SOUTHEASTERN CONNECTICUT
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INSURANCE INFORMATION

As a courtesy to our patients, we file your dental insurance. Dental insurance is not like medical coverage and rarely covers the same percentages. Your dental insurance is a contract between your employer and your insurance company for your benefit. The professional treatment and dental services offered by Orthodontic Associates of S.E.C.T. are for your best oral health and will not be dictated by insurance coverage.

You are responsible for the deductible and percentage not covered by insurance for the work performed by Orthodontic Associates of S.E.C.T. For insurances that do not pay our office directly, you will be responsible for payment in full and we will submit insurance claims with payments to be sent to you. We have many payment options, including cash, credit, or check, and we are available at any time to discuss the best option for you.

We file many of our claims electronically, therefore a signature on file is required by all dental insurance companies. We must have a completed insurance form along with social security number and date of birth to file your insurance.

We will do our best to help you maximize your dental benefits, however, ultimate responsibility for payment is yours and financial arrangements must be defined prior to beginning treatment.

INSURANCE INFORMATION NEEDED TO FILE YOUR CLAIM

Patient's Name: _____

Policy Holder's Name: _____Relationship to Patient: _____

Policy Holder's Mailing Address:_____

Policy Holder's Phone Number:_____

Policy Holder's Date of Birth:_____Policy Holder's SS# and/or ID:_____

Insurance Company Name:_____ Policy Holder's Employer:_____

****If you have a secondary insurance, please check here ___ and fill out another insurance information form.****

RELEASE OF INFORMATION (Policy Holder Only)

I authorize release of any dental information necessary to process insurance claims.

Policy Holder's Signature:_____Date_____

I hereby authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me.

Policy Holder's Signature:_____Date_____

FINANCIAL POLICY (Responsible Party Only)

I understand that I am responsible for any balance not paid by the insurance.

Responsible Party's Signature:_____Date:_____

Revised 9/2013