

Understanding Dental Assistance (Insurance)

We believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but most don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know...

Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly.**

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of \$1,000. You'll be surprised to know today that the average dental benefit plan has a yearly maximum cap of \$1,000. **There has been no significant increase in the yearly maximum cap in 40 years!** However, there have been significant increases in your premiums. **Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."**

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum or limitations. It is more realistic to expect dental benefit plans to cover between 25% and 40% of dental services. **Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan.** You will get back only what your employer has put in, less the insurance company's profit margin.

Insurance companies do NOT cover many routine and newer dental services. As a courtesy, we will process your insurance forms. If your insurance does not pay within **60 days**, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that 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. Ultimately, you are responsible for all charges incurred in our office.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. We hope you will choose the best that dentistry has to offer.

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

Signature

Date

Again, we thank you for choosing us for your dental needs 😊

Our Financial Policy ☺

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve. These options will help you enjoy a healthy, beautiful smile and keep your budget in mind. Dental treatment is an excellent investment to your medical and psychological health. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask you to accept and adhere to the following financial arrangements regarding your dental treatment.

Optional Payment Terms:

1. **Discount for Cash (no insurance) Patients:** We will provide 2 complimentary exams per year at your re-care appointments. We also provide an **8% discount** for restorative dental services (**CASH ONLY**) and **5% discount** for restorative dental services (**DEBIT/CREDIT CARDS ONLY**).
2. **Term Loan:** By arrangement with **Care Credit, Chase Health Financial** or **Sprinstone**, we offer our patients an **interest-free** term loan with no down payment, no annual fee, and no prepayment penalty (**subject to approval**). Please ask for an application or fill one out at www.CareCredit.com, www.ChaseHealthAdvance.com or www.SpringStonePlan.com to see which plan works best for you.

FOR OUR PATIENTS WITH DENTAL INSURANCE:

Because we understand that dental insurance plays a role in helping defray some of the costs of dental care, we would like to share with you the following facts about dental insurance.

Dental insurance is not meant to pay-all...it is meant only to assist in paying for your dental care. Dental insurance plans have no correlation to actual patients needs. As such, many routine and necessary dental services are not covered, even though you may need those services. Our responsibility is to provide you with the best care and treatment to meet your needs, not try to match your care to insurance plan limitations.

Many plans actually pay less than what you might expect. The benefits your plan pays are largely determined by how much your employer or union pays in premiums for the plan. We are happy to submit your claims and help you to receive the maximum benefits due to you, but please understand that we cannot accept responsibility for collecting an insurance claim, or for negotiating disputed claims.

Payments are expected at the time services are rendered. We accept cash, checks, debit cards, and all major credit cards. A \$25.00 per month late fee will be charged to all accounts 30 days past due. Accounts that are 60 days past due, will be pursued by a collection agency and will be charged an additional \$25.00 California service fee.

Appointment Set-Up Fee

A specific amount of time and materials is reserved especially for you and we strongly encourage all patients to keep their appointments. **If you must change your appointment, we require at least a 48 business hour notice to avoid a \$50.00 appointment set-up fee.**

I have read, understand and accept the terms of the above outlined financial policies. I (not my insurance company) am ultimately responsible for all fees incurred from services rendered.

Signature _____ Date _____

Again, we thank you for choosing us for your dental needs and rest assured optimal dental care will ALWAYS be provided here☺

PAYMENT PLAN CREDIT APPLICATION

PLEASE COMPLETELY FILL OUT THE BACKSIDE OF THIS PAGE

1. APPLICANT INFORMATION

Name (First-Mid-Last)	Date of Birth	Social Security # ____ - ____ - _____	Home Phone # (____) _____
Mailing Address Apt#	City	State	Zip
* If the above address is a PO Box, you MUST provide a street address for yourself or a contact person			Cell/ Other Phone #
Contact Person Name	Street Address	City	State Zip
Housing Information <input type="checkbox"/> OWN <input type="checkbox"/> RENT <input type="checkbox"/> OTHER Monthly Pmnt: \$ _____	Drivers License: # _____ Exp. Date: / /	Monthly Net Income From All Sources: \$ _____ Source: _____	Employer: _____ Phone: (____) _____
How Long: Yrs: Mo:			
Email Address:	Position: _____ How Long: _____		

2. CO-APPLICANT INFORMATION

Name (First-Mid-Last)	Date of Birth	Social Security #	Home Phone # ()
Mailing Address Apt#	City	State	Zip
* If the above address is a PO Box, you MUST provide a street address for yourself or a contact person			Cell/ Other Phone #
Contact Person Name	Street Address	City	State Zip
Housing Information <input type="checkbox"/> OWN <input type="checkbox"/> RENT <input type="checkbox"/> OTHER	Nearest Relatives Phone # ()	Employer Name	Employers Phone # ()
Monthly Net Income From All Sources \$ _____	Email Address		
Co-Applicant ID Type / Number # _____ Drivers License State Issued	Exp. Date	Co-Applicant 2nd ID Type	Issuer Exp. Date

3. NEAREST RELATIVE INFORMATION

Name (First-Mid-Last)	Home Phone # ()
Mailing Address Apt#	City State Zip
* If the above address is a PO Box, you MUST provide a street address.	
Street Address	City State Zip
E-Mail Address:	

3. APPLICANT & CO-APPLICANT: We need your signatures(s) below

I am providing the information in this application to Jose Arthur Mirelez, Jr., DDS, Inc, to CareCredit LLC, to Chase Financial and other credit program agencies that will assist me with my dental related financial obligations. By applying for this, I authorize and agree that:

*Dr. Mirelez may furnish this and other information about me (even if application is denied) and my account to credit agencies)

*Dr. Mirelez may make inquiries it considers necessary (including requesting reports from consumer reporting agencies and other sources) in evaluating my application, and for purposes of reviewing, maintaining or collecting my account.

*If my application is approved, the credit agencies agreements will be sent to me and will govern my account.

*Among other things, the Agreement: (1) INCLUDES AN ARBITRATION THAT MAY LIMIT MY RIGHTS UNLESS I REJECT THAT PROVISION UNDER THE AGREEMENT’S INSTRUCTIONS; and (2) makes each applicant responsible for paying the entire amount of credit extended; and (3) grants the credit agency a security interest in the goods purchased on the account as permitting by law.

*This application and the Agreement are governed by federal law and the credit agency state law (to the extent that state law applies).

Federal law requires us to obtain, verify and record information that identifies you when you open an account. We will use your name, address, date of birth, and other information for this purpose. If I have been pre-approved, I request you open the type of account for which I was pre-approved. We reserve the right to refuse to open an account in your name if we determine that you no longer meet our credit criteria.

Signature of Applicant	Signature of Co-Applicant (if applicable)
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(Please Do Not Print)	(Please Do Not Print)
Date :	Date: