The Apprehensive Patient of Secaucus

Authorization to Release Information

I hereby authorize the Apprehensive Patient of Secaucus, to provide my (or my spouse's) insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for evaluation and administrating claims for insurance benefits.

Insurance and Patient Responsibility

You have requested that we bill you insurance company directly for your dental treatment and we are happy to extend the courtesy to you providing you agree to the following:

You agree to sign your insurance form (if a signature is required) indicating that this office will be paid directly by the insurance company.

You agree to pay any difference between the amount paid by the insurance company and the amount due. Please understand that we are required by law to collect co-pays due from you in the amount determined by your insurance company. The Apprehensive Patient of Secaucus will ***estimate*** to the best of our ability, the amount of benefits that your insurance company will provide. **Apprehensive Patient of Secaucus is not responsible for any difference between the estimated benefit amount and the actual amount paid.**

Each patient is ultimately responsible for the payment of his/or her account. Our office will submit all necessary forms and information required to process your claim, and in necessary cases even contact your insurance company in an attempt to facilitate payment. This office is not, however, responsible for negotiating with your insurance company regarding a settlement on a disputed claim. Apprehensive Patient of Secaucus will provide any relevant information to aid our patients who need to make inquires to their dental insurance provider(s).

Please sign below to indicate that you have **READ, UNDERSTOOD, AND AGREE TO**

THE ABOVE POLICIES.

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_____

Name (Please Print)
Date

_____

Sign