

INSURANCE INFORMATION AND PAYMENT POLICIES

It is important to understand that whether or not you have insurance, the fee for any service provided is your responsibility. If you have dental insurance, we will help you estimate your benefits. There are many factors that can impact your estimate. These include, but are not limited to, services performed at another office, treatment plan changes, benefit exhaustion, insurance fee schedules, or plan termination.

If you are uninsured or paying for your care yourself, we have included information about the **No Surprises Act** and your right to receive a **Good Faith Estimate**. The purpose of this policy is to establish standardized procedures for identifying eligible patients, preparing, delivering, documenting, and maintaining Good Faith Estimates (GFEs) in compliance with the No Surprises Act (42 U.S.C. §300gg-111 and 45 CFR Part 149). This policy is intended to ensure transparency regarding anticipated charges for healthcare services provided to uninsured or self-pay individuals while maintaining compliance with all applicable federal requirements.

Payment is due at each visit with the total estimated remaining balance due by completion of treatment. Any balance remaining after insurance processing, whether denied, partially paid, or changed in any way, is the full responsibility of the patient/parent. My signature below certifies that I understand and agree to pay Frederick J. Norfolk, DMD the total amount due for any and all services rendered.

Frederick Norfolk & Associates participates with the following plans: Delta Dental Premier and Blue Cross and Blue Shield Indemnity, PPO, & Medicare Advantage. All other plans are considered out of network. We strongly encourage you to confirm with your insurance or provider prior to scheduling an appointment.

Patient / Parent Signature _____ Date _____

Dental Insurance ☐ Yes ☐ No (if yes, please complete below.) If there is more than one insurance, please ask for an add'l form

Subscriber Information

Name: _____ Social Sec.Number: _____ DOB: _____

Address: _____ Town/City: _____ State: _____ Zip: _____

Home Phone Number: _____ Business Phone Number: _____

Place of Employment: _____

Name of Dental Insurance Carrier: _____

Insurance Billing Address P.O. Box # or Street: _____

Town/City: _____ State: _____ Zip: _____ Phone #: _____

ID#: _____ GROUP NUMBER: _____

Patient/Parent Signature for Assignment of Benefits: _____

(Your signature here authorizes your insurance company to send payments directly to the provider of dental services. If this line is unsigned, your insurance benefits would be sent directly to you and payment of dental services would be due at the time of service.) Your signature also authorizes us to release copies of dental related radiographs or information to your insurance.

CONSENT TO TREATMENT

I consent to the performance of dental services deemed necessary or advisable. Further, I certify that the information provided on this form is accurate and correct to the best of my knowledge.

Signature of Patient/Parent: _____

Date: _____

Doctor Signature: _____

Date: _____