JAMES S. TRICHAK DENTISTRY

16841 N. 31ST AVENUE, SUITE 140

PHOENIX, AZ 85053

(623) 938-4373

INSURANCE INFORMATION WORKSHEET

_____ _____

FAMILY LAST NAME DATE

Name of Policy Holder _____ Relationship _____

Date of Birth _____ Social Security_____ Insurance ID_____

Employer/Company_____

Insurance Company _____

Insurance Co Address_____

Ins. Phone # _____ Group # _____ Effective Date _____

Other Family Members Insured on this plan and their birthdates _____

_____

SECONDARY INSURANCE (if applicable)

Name of Policy Holder _____ Relationship _____

Date of Birth _____ Social Security_____ Insurance ID_____

Employer/Company_____

Insurance Company _____

Insurance Co Address_____

Ins. Phone # _____ Group # _____ Effective Date _____

Other Family Members Insured on this plan and their birthdates _____

_____

_____

PRINT NAME

JAMES S. TRICHAK DENTISTRY
16841 N. 31ST AVENUE, SUITE 140
PHOENIX, AZ 85053

INSURANCE AGREEMENT

For our patients who are requesting that our office carries a balance on their account, in anticipation of insurance payment. This form must be signed by the patient of responsible party before we can submit for payment directly form an insurance company.

1. I understand and agree that the amount estimated to remain unpaid by the insurance is to be paid by me at the time of treatment.

2. I understand that this office cannot make an exact estimate of the anticipated benefits due to the diversity in insurance plans, policies and provisions.

3. I understand and agree that after the insurance company pays, there still could be a remaining balance which I will pay in full within 10 days of billing.

4. I understand that this office cannot wait more than 60 days for payment from my insurance company. If the claim is not paid in that time the entire amount is due and payable by me.

5. I understand that this office, as a courtesy to me, will submit claims to my insurance company at no charge. It is my responsibility to provide the office with all the necessary information. If a claim is resubmitted due to my failure to provide updated information there will be a $15.00 charge for each claim.

6. I understand and agree that if the estimate of insurance benefits indicates a large amount due by me which I feel I cannot pau at the time of treatment, I must discuss and make financial arrangements prior to scheduling.

7. I understand that recommended treatment is based upon patients dental health needs, NOT on insurance benefits. The determination of proper treatment is a matter best decided by the patient and Dr. Trichak. It is not a matter to be dictated by unseen third party whose total motivation is the protection of the insurance company profit margin.

8. I understand that my insurance is a contract between me and my carrier and not this office. I realize this office cannot know all the clauses, exclusions, limitations and eligibility of my insurance plan. It is my responsibility to question my insurance administrator if I have any concerns. A pre-determination of benefits is not done routinely in this office. This office will submit a pre-determination, one time, for any procedure requiring x-rays upon my request.

X _____ Date _____
I authorize the release of any information necessary to process my insurance claim

X _____ Date _____
I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me

X _____ Date _____
I have read and understand, and accept the terms of the above insurance agreement