Summit Smiles LLC

Insurance Agreement

As a courtesy, Summit Smiles will collect as much information as possible regarding a patient's insurance coverage such as effective dates, maximum, deductible, percentages covered. Ultimately, it is the patient's responsibility to keep track if they have reached their maximum, when their coverage period begins and ends, and what is or not covered. Insurance does not guarantee any payment to our office until treatment is complete and claims have been received and processed by the insurance company. **All information obtained by Summit Smiles is NOT a guarantee of benefits. The patient is ultimately responsible for payment of all services rendered**.

It is our office policy to collect payment on date of service rendered. We estimate to the best of our knowledge what the patient's responsibility will be at that time. Any difference in that amount will be the patient's responsibility. Insurance claims are submitted by Summit Smiles as a courtesy.

I also understand that should my insurance company send payment to me, I will forward the payment to Summit Smiles within 48 hours. I agree that if I fail to send the payment to the provider, they are forced to proceed with the collections process. I will be responsible for any cost incurred by the office to retrieve their monies. Any violations of this agreement will terminate patient charge privileges with provider and bring any balance owed by patient immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, **or if there is a remaining copay after insurance payment,** I authorize Summit Smiles to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ Date _____

Signature of Policyholder

_____

Patient/Guardian