



To My Patients:

During the past decade, dental benefit plans have become an integral part of the health care planning for many families.

Dental benefit plans are made available to employees or members, through companies, unions, and associations, and may vary considerably from one plan to the next.

The range of benefits depends solely on what the purchaser wishes to offer employees or members. Some plans may cover as little as 30% or as much as 100% of dental services, with most falling in the 50% to 80% range. Some plans exclude certain types of services, examples, orthodontics, while other plans will cover a full range of dental services.

Some plans base the amount of benefit on a chart or schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage of the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of dental treatment, it means 80% of the fee arbitrarily determined by the insurance company, and not the actual fee charged by me.

As the number of patients covered by dental benefit plans has increased, certain assumptions have become evident and I would like to make the principles of my practice, as well as the type of service and care I provide my patients, very clear.

- My fees are based on the overhead involved in my practice, the treatment plan selected, and the time it takes me to provide you with the necessary dental care. I do not believe it is in either of our best interests for me to compromise my recommended treatment in order to accommodate an insurance program's maximum benefits, that may be considerably less than optimal. However, I am more than happy to discuss a treatment plan's advantages and disadvantages with you thereby involving you, rather than your insurance company, in the decision-making process.
- The type of treatment you need and receive from me is based upon my professional judgment, and not on whether you are covered by a dental benefit plan.
- The financial obligation for dental treatment is between you and this office. Your dental benefit plan is a contract between you, your employer and the insurance company. We are not a party to that contract.
- If the insurance company pays its share of the cost directly to my office, you will receive credit for this amount and be billed for the balance. If you receive direct payment from the insurance company, payment is due in 30 days from the time of service.
- If your dental benefit plan requires a "predetermination" or "prior authorization", I will submit a treatment plan for review by your insurance carrier. However, please remember that the financial obligation for dental treatment is between you and this office. The insurance company is responsible to you and not to this office.
- If your insurance carrier has not paid within the 30 days (which is required by law) from the date the insurance was filed, you will receive a statement for the unpaid balance. It is your responsibility to contact your insurance carrier for payment, processing follow-ups, lost claims, etc.
- If you receive a communication from your insurance carrier suggesting that my fee is over and above the usual and customary rate for the services provided to you, please do not accept this as true without first discussing the matter with me. The insurance carrier's fee data may be extremely out of date, or not taken into consideration local factors pertaining to Shelby County and the surrounding area in establishing its schedule.
- If, after our discussions, you believe that the dental benefits provided by your plan are inadequate, you may want to discuss the matter with your employer, union, or association, so that appropriate alternatives can be investigated.

If at any time you have questions regarding your treatment, benefit plan, or statement, please discuss them with us promptly. We will make every effort to avoid a misunderstanding and to preserve a friendship.