To Our Valued Patients:

We would like to inform you of the ongoing challenges we face with dental insurance companies in trying to provide you with the **very best of care** and **at the same time minimize your out of pocket expense**. Today dental x-rays, a very necessary part of a thorough examination, is being covered by some insurance carriers to a lesser degree in their attempt to save costs. We at Taylor Brook Dental Associates would like to be proactive in making you aware of their actions and informing you of your responsibilities as a patient and/or policy holder.

- Dental x-rays are necessary for accurate diagnosis of many dental conditions. They allow dentists to detect decay and other diseases of the mouth, bone, face and jaw that many times is not visible during an oral examination. Early intervention of such pathologies/cavities can save tooth structure and cost to the patient.
- Our staff is here to help you understand your dental insurance coverage. We can, upon request, gather information about waiting periods, maximums, deductibles and frequency limitations, **however there can be policy provisions that insurance companies do not disclose to us.**
- **We cannot guarantee that your insurance will cover any procedure.**
- **You are responsible for your insurance coverage, their practices and any unpaid balance.**

PAYMENT IS DUE AT THE TIME OF SERVICE

- **Our office files insurance benefits as a courtesy to you.**
- **All deductibles, copayments, and non-covered fees are due at the time of service.**
- **Interest free payment plans are available through CareCredit.**
- **We accept cash, checks, Visa, MasterCard, Discover, and American Express.**

Authorization: I understand that Taylor Brook Dental Associates cannot guarantee insurance coverage. I understand that I am responsible for any unpaid balance not covered by insurance. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to TBDA all insurance payments otherwise payable to me. I understand that I am responsible for the full balance.

____ Date: ____________________

Signature of Patient, Parent, or Guardian (Financially Responsible Party)

______________________________   ____

Printed Name of person signing   Patient Name (if different)