Family Dentistry

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Manon Bourque Hutchison, D.D.S.

Important Dental Insurance Information For Our Patients

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductible and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for a short turnaround.
3. Researching your dental insurance plan to advise you of benefits available to you.
4. If necessary, re-filing your insurance a second time within 60 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. **Payment of fees (not covered by your insurance plan) at the time the service is delivered.**
2. **Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.**
3. **Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.**
4. **Taking responsibility for payment if the insurance company does not pay our office within 30 days.**
5. **Keeping our office informed of any changes in your insurance coverage or employment.**

Thank you for your cooperation with your dental coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

I hereby authorize Dr. _____ to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. _____

I understand I am responsible for any unpaid balance.

Signature: _____ Date: _____

Coconut Creek Office • 5359 Lyons Road • Coconut Creek, FL 33073 • 954-570-8870
Pompano Beach Office • 2631 E. Atlantic Boulevard • Pompano Beach, FL 33062 • 954-942-4048