PDA DENTAL GROUP
PEDIATRIC | ORTHODONTIC | ADULT

955 Main Street, Suite 101 | Winchester, MA 01890 | 781-729-1900
54 Haven Street | Reading, MA 01867 | 781-944-7799
www.pdadentalgroup.com

INSURANCE INFORMATION

Insurance Plans for Pediatric and Adult Dentists

We are **Participating Providers** with:

Delta Dental PREMIER and DMIC
Blue Cross Blue Shield Indemnity

We are **Preferred** with:

Altus Dental
Cigna PPO
MassHealth for patients under 18

Insurance Plans for Orthodontists

We are **Participating Providers** with:

Delta Dental PREMIER and DMIC
Blue Cross Blue Shield Indemnity

We are **Preferred** with:

Altus Dental

Orthodontists do **NOT** accept MassHealth

Please complete your insurance information:

Primary Insurance Carrier		Secondary Insurance Carrier	
Subscriber Name		Subscriber Name	
Subscriber ID#		Subscriber ID#	
Subscriber Employer		Subscriber Employer	
Insurance Carrier		Insurance Carrier	
Group #		Group #	
Claims Address		Claims Address	
Claims City, State, Zip		Claims City, State, Zip	
Claims Phone Number		Claims Phone Number	

Signature of Insurance Policyholder_____

FINANCIAL INFORMATION

We are committed to providing you with the highest quality dental care. In order to achieve this goal, we appreciate your assistance and understanding of our financial policy and your insurance benefits.

Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you, your employer and your insurance company, not between your insurance company and the dental office. We will file your primary and secondary insurance claims as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to the coordination of benefits with the primary insurance. In addition, not all services are a covered benefit with all insurance plans. Your employer and insurance carrier determine your coverage. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your estimated copay at the time of service per your insurance company. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. If you do not have dental insurance, payment is due day of service. We accept cash, personal check, debit/credit card, MasterCard, Visa, Discover, American Express and Care Credit.

Statements are sent out monthly and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. Balances not paid within 90 days may be turned over to a collection agency, unless prior payment arrangements have been made. We will work with patients to set up a mutually feasible payment plan if necessary. Patient payments are typically applied to the oldest balances first. Returned checks are subject to a $25 fee. Charges may be incurred for broken appointments and appointments cancelled without 24-hour notice. Please contact the billing office if you have any questions about our fees, financial policy or your responsibility.

I authorize my insurance company(s) to pay benefits directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that my dental insurance carrier may pay less than the actual billed services. I understand I am responsible for the cost of all dental treatment. I agree to be responsible for all copayments, deductibles, rejected charges and all services that the insurance does not cover rendered on my behalf or my dependents. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors otherwise payable to me. I understand that I will be responsible for any fees if third party collection efforts are required to collect a balance, and for any returned check fees. I also understand that there will be a charge for any missed appointments or appointment cancelled with less than 24-hour notice.

I have read the above information and understand my obligations.

Signature of Financially Responsible Party_____