INSURANCE AGREEMENT

THANK YOU FOR CHOOSING OUR OFFICE TO PROVIDE FOR YOUR ORTHODONTIC NEEDS. AS A SPECIAL SERVICE TO YOU, WE ASSIST IN FILING OF INSURANCE CLAIMS SO THAT YOU MIGHT RECEIVE THE FULL BENEFIT AVAILABLE FROM YOUR INSURANCE COVERAGE. WE PERMIT YOU TO USE YOUR ORTHODONTIC BENEFIT TO LOWER YOUR PORTION OF THE COST OF ORTHODONTIC TREATMENT, RATHER THAN PAYING THE FULL FEE UP FRONT AND WAITING FOR REIMBURSEMENT FROM THE INSURANCE COMPANY. THIS ALLOWS YOU THE FINANCIAL FREEDOM OF PAYING ONLY YOUR PART OF THE TREATMENT FEE WHILE WE ACCEPT DIRECT PAYMENT FROM YOUR INSURANCE COMPANY. IN RELIEVING YOU OF THIS FINANCIAL BURDEN, WE ALLOW OURSELVES TO BE VULNERABLE TO THE INSURANCE COMPANY, THEREFORE, WE HAVE SET SOME GUIDELINES AND LIMITATIONS WHICH MUST BE RECOGNIZED AND ADHERED TO.

PECULIARITIES:
WE CANNOT BE HELD RESPONSIBLE FOR KNOWING ALL THE PECULIARITIES AND REQUIREMENTS OF ALL INSURANCE COMPANIES WE DEAL WITH. IT IS YOUR RESPONSIBILITY TO BECOME FAMILIAR WITH YOUR OWN POLICY. IF THERE IS A PECULIARITY ABOUT YOUR INSURANCE COMPANY OF WHICH YOU DID NOT INFORM US, AND IT RESULTS IN AN UNDERPAYMENT OF ESTIMATED BENEFITS, WE WILL NOT BE HELD RESPONSIBLE AND THE UNPAID AMOUNT WILL BE APPLIED TO YOUR PORTION OF THE ACCOUNT.

CHANGE IN BENEFITS, ELIGIBILITY OR CARRIER:
AT ANY POINT IN TREATMENT, IF YOU CHANGE JOBS OR BECOME INELIGIBLE FOR ORTHODONTIC BENEFITS, YOU MUST NOTIFY US IMMEDIATELY AND WE WILL AVERAGE ANY REMAINING BENEFITS ORIGINALLY ANTICIPATED INTO YOUR MONTHLY PAYMENTS.
AT ANY POINT IN TREATMENT, IF YOUR EMPLOYER CHANGES INSURANCE CARRIERS, YOU MUST NOTIFY US IMMEDIATELY. IF THE NEW POLICY DOES NOT HAVE AS MUCH COVERAGE OR DOES NOT HAVE ORTHODONTIC COVERAGE, WE WILL AVERAGE ANY REMAINING BENEFITS ORIGINALLY ANTICIPATED INTO YOUR MONTHLY PAYMENTS.

INTENTIONAL OR UNINTENTIONAL WITHHOLDING OF BENEFITS
WHEN BENEFITS ARE ASSIGNED DIRECTLY TO THIS OFFICE, IF THE INSURANCE COMPANY SENDS A CHECK TO YOU IN ERROR, WE WILL HOLD YOU RESPONSIBLE FOR IMMEDIATE AND COMPLETE REIMBURSEMENT. SHOULD YOU RECEIVE A CHECK FROM YOUR INSURANCE COMPANY, MAIL OR BRING IT TO THIS OFFICE. ANY ATTEMPT TO WITHHOLD INSURANCE FUNDS RECEIVED BY YOU IN ERROR WILL RESULT IN AN IMMEDIATE TERMINATION OF THIS INSURANCE AGREEMENT AND WE WILL HOLD YOU DIRECTLY RESPONSIBLE FOR THE BALANCE OF THE PAYMENTS DUE.

I CERTIFY THAT I AM / MY DEPENDENT IS COVERED BY DENTAL INSURANCE AND ASSIGN DIRECTLY TO MICHAELA M. MCCORMICK DMD, PC ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

MCCORMICK ORTHODONTICS MAY USE MY /MY CHILD'S HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN THE CURRENT TREATMENT PLAN IS COMPLETED.

PATIENT'S NAME DATE

SIGNATURE OF PATIENT, PARENT OR GUARDIAN