

INSURANCE INFORMATION

Patient's Name:

- I have dental insurance and request that Virginia Dental Solutions file my claims for me.
- I have both primary and secondary insurance plans.
- I have no dental insurance.
- I have dental insurance but wish to file my own claims

Primary Insurance Information

Name of Insured: _____	Employer: _____
Insured Social Security #: _____	Insurance Company: _____
Insured Identification #: _____	Group # _____
Insured Date of Birth: _____	Group Coverage? ____ Single Coverage? ____
Effective Date of Policy: _____	

Relationship of patient to the insured: _____
 _____ Self _____ Spouse _____ Child _____ Other (Please Specify)

Mail claims to: _____

Secondary Insurance Information

Name of Insured: _____	Employer: _____
Insured Social Security #: _____	Insurance Company: _____
Insured Identification #: _____	Group # _____
Insured Date of Birth: _____	Group Coverage? ____ Single Coverage? ____
Effective Date of Policy: _____	

Relationship of patient to the insured: _____
 _____ Self _____ Spouse _____ Child _____ Other (Please Specify)

Mail claims to: _____

Many insurance companies have stopped using social security numbers and are using a subscriber number instead. If your insurance still uses your social security number we **MUST** have the complete nine digit number, not the protective X's printed on your card.

Insurance filing is a courtesy provided to the patients and is in no way a responsibility of the office. We must have the correct information as well as your signature on file at the time of service. If not, you will need to file your own claims.

I hereby authorize payment of benefits directly to Virginia Dental Solutions. I understand that I am responsible for charges not covered by my carrier. A photocopy of this authorization shall be considered as valid as the original.

Patient or Parent/Legal Guardian Signature

Date

Office Financial Policies

Dental Insurance

If you have insurance through your employer, and you are the policy holder, (the insurance is in your name) this insurance will be primary for you, and your spouse's insurance policy will be secondary. The insurance policy thru your spouse's employer would be their primary and your policy would be their secondary.

Children that are covered by two insurance plans generally fall under the "birthday rule" if there are two plans. Under this rule, the plan of the parent whose birthday occurs first in the calendar year is designated as primary. The date of birth is the determining factor—not the year—so it doesn't matter which spouse is older.

Your insurance coverage is determined by what your employer has purchased. Payments for services can vary widely from policy to policy. Some procedures may be denied based on age, pre-existing conditions or length of time on the plan. These restrictions are based on your specific plan as determined by your employer's contract with the insurance company. If you are unsure about your insurance coverage, we advise you to contact your dental insurance carrier for information and clarification about your benefits.

UCR's (usual and customary rates) are applicable only to plans with which we participate (i.e. Delta Premiere – USA, Aetna PPO, DeCare/Teamsters and some United Concordia plans).

Delinquent Accounts

Interest in the amount of 1% per month (12% annum) will be charged to all accounts over 90 days past due. In the event that your account is referred to an attorney for collection, the undersigned is required and agrees to pay all court costs plus an amount equal to 1/3 of the unpaid principal as an attorney fee.

Returned Checks

A fee in the amount of \$20.00 will be charged for all returned and "insufficient fund" checks.

Broken and Cancelled Appointments

If you are unable to keep your scheduled appointment, we ask that you give us a minimum of 24 hours notice. If sufficient notice is not given, a charge may be assessed.

By signing below, I certify that I have read the financial policies (stated above) and understand these policies. I agree to abide by the policies above for treatment provided by the practice of Drs. Novick, Hartz, Hall, Novick, Sharma, Martinez and their associates. I certify that all information provided is correct. I hereby authorize the doctors and staff to release personal information to the insurance company for all persons on my account. **I understand that the account balance is ultimately my responsibility regardless of insurance coverage and payments.** I understand and agree that the terms herein are reaffirmed each time services are rendered.

Signature of Responsible Party

Print Name

Date

VIRGINIA DENTAL SOLUTIONS	
11325 Sunset Hills Road	44095 Pipeline Plaza, #220
Reston, VA 20190	Ashburn, VA 20147
(703) 437-8811	(703) 858-0000