Schulz Orthodontics

Specialists in Orthodontics for Children and Adults

FINANCIAL POLICY

We are committed to providing you with the best possible orthodontic care. We also want to serve you in a manner which is as comfortable and pleasant as possible. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment, give you as detailed an estimate as possible in writing, and answer any questions that we can about your insurance. If you have orthodontic insurance, we will assist you in receiving your maximum allowable benefits.

We cannot emphasize too strongly that the extent of your insurance benefits is defined in a contract between you, your employer and an insurance company. We are not a party to that contract. We had no input into any of the decision-making. As your orthodontic care providers, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claim form and sending it in promptly. Payment can be made by cash, check or credit card.

We realize that a temporary financial crisis may affect timely payment of your account. If such a crisis does develop, we encourage you to contact our office immediately for assistance in redefining the payment terms of your account. By keeping the line of communication open, we can avoid any misunderstandings that would interfere with our positive relationship.

Patient Name:_____Date of Birth:

Primary Dental Insurance

Insured's Name:_____

Relationship to Patient:_____

Insured's SS#:_____

Insured's Birthdate:_____

Insured's Employer:_____

Insurance Co. Name:_____

Group #: _____

Enrollee ID: _____

Insurance Co. Address:_____

_____

Insurance Co. Phone:_____

Orthodontic Coverage:_____

Secondary Dental Insurance

Insured's Name:_____

Relationship to Patient:_____

Insured's SS#:_____

Insured's Birthdate:_____

Insured's Employer:_____

Insurance Co. Name:_____

Group #:_____

Enrollee ID: _____

Insurance Co. Address:_____

_____

Insurance Co. Phone:_____

Orthodontic Coverage:_____

Parent Signature_____Date_____