INSURANCE:

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. Your dental benefits are a contract between you, your employer and the insurance company. We will prepare forms and reports to assist you in obtaining maximum benefits available, however the dentist's treatment recommendations or fees are not influenced by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental insurance benefits.

If the patient is interested in trying to maximize his or her insurance benefits while undergoing treatment at Renew Institute: Beyond Dentistry, it is necessary for us to keep all insurance records on file as to accurately fill out all insurance claim forms. By taking the below information Renew Institute: Beyond Dentistry cannot guarantee insurance coverage for treatment.

PRIMARY DENTAL INSURANCE, Please print

Individual Responsible for Insurance:

____

(Last Name) (First Name) (Middle Initial)

Birth Date: _____________________ Gender (Circle One) Male Female

Employer Name____

Employer Address____

Subscriber Identifier (SSN or ID #)____

Plan / Group Number____

Insurance Company Name ____

Insurance Company Address ____

City ____ State ___________ Zip ____________

Patient's Relationship to Subscriber (Circle One) Self Spouse Dependent Child Other

Student Status (Circle One) Full-time Part-time

Patient Name:____

Street Address ____

City _____________________________________State ____________ Zip_______________

Birth Date:____________________ Gender (Circle One) Male Female

ASSIGNMENT AND RELEASE

I have been informed of the treatment plan and the associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

____

Patient / Guardian (if a minor) signature **Date**