Seth M. Roth D.M.D.
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OFFICE POLICY REGARDING INSURANCE

For over 20 years our office has taken great pride in assisting our patients with understanding their dental benefits. Although we will continue to do our best to estimate insurance copayments, the patient is ultimately responsible in full for all dental services rendered. Due to the constant changes in benefits, the unreliability of websites, the human error of insurance representatives, on hold time averaging 15-30 minutes per issue and outdated and inaccurate paperwork supplied to our staff, we can only guess what your insurance might pay. Patients need to become educated and fluent in the frequencies, limitations, exclusions, and eligibility criteria of your dental benefits directly from your insurance handbooks or benefit administrators. Patients are responsible for scheduling according to their allowed frequencies and ultimately responsible for payment in full of all unpaid insurance portions. Initial_____

If we cannot positively verify your coverage prior to the day of service you will need to pay in full at the time of service. If you have new insurance, please contact our office at least one day before the appointment with the new information. Please verify your Full Time Student Status with your insurance company prior to your appointment. Initial_____

You have a contractual relationship with your insurance company and your employer which has nothing to do with this office. The insurance company and the employer have contracted with one another to limit the services that they will pay for to be financially beneficial to the employer and the insurance company but they are not ultimately concerned with your optimum dental health. Dr. Roth has a relationship with you, the patient, and is concerned that you have a healthy mouth, are comfortable chewing your food, and that you are proud to smile.

I, the undersigned, have read and understand that in order for Dr. Roth to agree to accept assignment of benefits that my signature represents consent to this policy.

Name_____ **Date**_____