OFFICE INSURANCE POLICY AND ASSIGNMENT OF BENEFITS

I understand that an insurance policy is not a guarantee of payment. While every effort will be made to insure the accuracy of my insurance plan benefits, I understand that the office estimate of my insurance benefits is NOT a guarantee of accuracy and in fact will **not be exact**. I understand that a pre-determination of benefits will result in the most accurate estimate of my insurance plan benefits, however even a pre-determination of benefits is NOT a guarantee of payment by the insurance company.

I understand that the office will file for a pre-determination of benefits only on estimated treatment exceeding $300.00 and that a pre-determination of benefits may take in excess of six weeks to be processed by my insurance company. I understand that the filing of my insurance claim is a courtesy extended to me by the office and that the office is not an agent for my insurance company, and has no control or influence over them, their policies or their payments.

I understand that my insurance company has not examined me and does not know my dental condition and dental needs. I understand that my insurance company may deny payment or change the treatment to a lesser cost treatment option and that this is done strictly for the economic benefit of my insurance company and not to my personal benefit. I understand that my insurance company may not pay for certain materials or procedures and that this is done for the economic benefit of my insurance company and not for my benefit. I understand that my insurance contract is between me, my employer and my insurance company and this office is not a party to that contract. So therefore I understand that I am responsible to monitor my dental benefit policy accordingly. I understand that Dr. Gleckner will recommend and use materials and treatment procedures that are in my best interest and not based upon my insurance company's payment considerations.

I agree to be responsible for the full amount of the charges for my treatment. If I elect to have payment (if any) made to the office by my insurance company, this will be applied toward the full amount of charges for my treatment.

I hereby authorize the release of any information pertaining to my treatment and claim to my insurance company by electronic submission through national clearing houses that are governed by the Health Insurance Portability and Accountability Act (HIPAA).

I hereby authorize payment to be made directly to Dr. Mark J. Gleckner of the group insurance benefits otherwise payable to me.

Insured Signature______________________________________ Date_____________