Thoroughgood Dental
1609 Pleasure House Rd
Virginia Beach Va 23455
757.464.3321

Financial Policy Consent Form

We welcome you and your family to Thoroughgood Dental and look forward to providing you quality care and a professional environment. To continue providing you with the service you've come to expect from our practice, we ask that you thoroughly read our financial policy and insurance filing updates. We are happy to answer any questions you may have and thank you for allowing us to care for your dental health.

Dental Insurance Benefits: You need to be aware that:

We will always do our best to help you maximize your benefits. Although we file for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.

Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Please note that in the state of Virginia, any services not covered by your insurance can be held to our in house dental fee and any adjustments are a courtesy provided directly by your dentist.

It is your responsibility to thoroughly understand the coverage and exceptions of our particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

Please read and sign on back

Dental Insurance Claim Payments:

As a courtesy to all of our insured patients, we will file your dental insurance claim forms. You are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance payment.

Your claim will be filed immediately, and benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of a timely payment on your account. If the claim is not cleared by your carrier in 90 days, or a maximum of 2 filed claims within a 3 month period, the unpaid portion will automatically become “self-pay” and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay for whatever reason.

I, _____ understand and accept the financial and insurance policies listed above and have had any and all questions answered to my satisfaction.

I, _____ agree to pay for all treatment in a timely fashion as described.

I, _____ hereby authorize my insurance benefits to be paid directly to Thoroughgood Dental. I realize that I am responsible to pay for any deductible amounts my co-insurance portion and for any non-covered services the day of service. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance. I agree to pay such charges in full.

I, _____ hereby authorize the release of pertinent medical/dental information to the insurance carrier. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is available by request.

Payment Options Available

: Cash/ Personal Check
: Most Major Debit Cards / Most major credit cards (3.5% fee)
: CareCredit (minimum $300)