ASPEN LEAF DENTISTRY, P.C.
1190 West Ash Street, Suite B
Windsor, Colorado 80550

To our patients who have dental insurance:

This office is happy to cooperate with families who are covered by dental insurance. We only ask that you read your policy to be sure that you are fully aware of any limitations of the benefits provided.

The fees we charge for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Your policy may base its allowances on a fixed fee schedule that may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the types of coverage available. Also, some companies pay claims promptly and others delay payment many months.

Since we had no say in the selection of your insurance company (nor do we feel we should) we have no control over when we shall be paid by them for services. Therefore, we ask that you look upon your insurance realistically as a device that reimburses you for dental expenses. It is your company, and it is your responsibility to see that you are reimbursed promptly. Our obligation is to complete all forms pertaining to your claim and send them promptly to your company to help you obtain the reimbursement you are entitled to receive. This often involves more paper work than we have been accustomed to doing, but we are happy to do it because we realize how important it is to you.
Our customary procedure in handling our patients' accounts is the same for patients with or without insurance coverage. An estimate of the fee is given. We then request that a definite financial arrangement be made with our business manager before any dental treatment is begun.

We will accept assignment of the benefits provided by your insurance company, and will consider that when arranging your payment schedule. Remember that our services are provided to you, and the responsibility for the full payment for those services will ultimately be yours.

Please feel free to discuss any facet of your dental insurance coverage with us.

Signature:_____Date:_____