Dr. Justin C. Kerr
Sunset Ridge Dental
9109-101 Sunset Drive
Cochrane, AB T4C0W8
(403) 981-3685

SUNSET RIDGE DENTAL CLINIC'S ASSIGNMENT OF BENEFITS POLICY

As a courtesy to our patients we will accept direct payment from your dental insurance and you are required to pay any outstanding balance of the treatment provided. **We strongly advise our patients to be well informed about their insurance plan as we do not have information about your plan.** If you have financial/insurance questions about coverage, we ask that you inquire before your treatment starts. You must sign the insurance Authorization (below) and a Credit Card Authorization (below). Because dental plans are numerous and varied we cannot know if your insurance will cover the full extent of the costs incurred for your dental treatment. **You will be responsible for any outstanding balance.**

1. **When the insurance company notifies us of the benefit payable at the time of service:** the balance must be paid by you at the time of service. The Credit Card will be retained on file for the balance when insurance pays their portion if no breakdown of coverage is given on the service date.

2. **If you have dual insurance:** any balance not covered by your insurance will be charged to your Credit Card on file.

If payment by your insurance company is delayed: when submitted via CDAnet, payment from most insurance companies is sent within a two week period, therefore, if payment is not received from the insurance company within 30 days of submission the total owing for the outstanding claim will be charged to the Credit Card on file.

ASSIGNMENT OF DENTAL BENEFITS AUTHORIZATION

Sunset Ridge Dental adheres to legislation in the Alberta Health information Act to keep your personal information private, including your Credit Card Authorization.

I hereby assign my benefits, payable from claims submitted electronically to the Dentist of Sunset Ridge Dental Clinic and authorize payment directly to them. This Authorization shall continue to effect until the undersigned revokes the same. I authorize Sunset Ridge Dental Clinic to keep this Credit Card and Signature on file for any estimated patient portion due from the time of service, for any unpaid balance after dental insurance payments are processed, or for any balance unpaid by the insurance company after 30 days.

Date_____ Print Name_____ Signature _____

Credit Card: ❑ Visa ❑ MasterCard Card #_____ Expiration Date_____ CC Security Code _____

Address_____ City_____ Province _____

Card Holder Name_____ Cardholder Signature _____

Family members included:

_____

_____

X_____ **X**_____ **X**_____

Signature of patient *(Parent or Guardian if Minor)* **Print Name** **Date**