INSURANCE INFORMATION AND PAYMENT POLICIES

It is important to understand that whether or not you have insurance, the fee for any service provided is your responsibility. If you have dental insurance, we will help you estimate your benefits. There are many factors that can impact your estimate. These include, but are not limited to, services performed at another office, treatment plan changes, benefit exhaustion, insurance fee schedules, or plan termination.

Payment is due at each visit with the total estimated remaining balance due by completion of treatment. Any balance remaining after insurance processing, whether denied, partially paid, or changed in any way, is the full responsibility of the patient/parent.

My signature below certifies that I understand and agree to pay Frederick J. Norfolk, DMD the total amount due for any and all services rendered.

Frederick Norfolk & Associates participates with the following plans: Delta Dental Premiere and Blue Cross and Blue Shield Indemnity. All other plans are considered out of network. We strongly encourage you to confirm with your insurance or provider prior to scheduling an appointment.

Patient / Parent Signature____________________________________ Date_____________

Dental Insurance ☐Yes ☐No *(if yes, please complete below.)* **If there is more than one insurance, please ask for an addt'l form**

Subscriber Information

Name: _____________________Social Sec.Number: __________________ DOB:____________

Address:___________________ Town/City: ____________________ State: _______ Zip: _______

Home Phone Number: ___________________ Business Phone Number: _____________________

Place of Employment: ____

Name of Dental Insurance Carrier: ____

Insurance Billing Address P.O. Box # or Street: ____

Town/City: ____________________ State: _______ Zip: _______ Phone #: ___________________

ID#: _____________________________GROUP NUMBER: ___________________________________

Patient/Parent Signature for Assignment of Benefits: ____

(Your signature here authorizes your insurance company to send payments directly to the provider of dental services. If this line is unsigned, your insurance benefits would be sent directly to you and payment of dental services would be due at the time of service.) Your signature also authorizes us to release copies of dental related radiographs or information to your insurance.

CONSENT TO TREATMENT

I consent to the performance of dental services deemed necessary or advisable. Further, I certify that the information provided on this form is accurate and correct to the best of my knowledge.

Signature of Patient/Parent:_______________________________ Date:_____________

Doctor Signature: ______________________________________ Date: _____________