ROBERT E. JEPKO, DDS PA 1155 Huffman Mill Road, Burlington, NC 27215 (336) 586-9696

FILING YOUR INSURANCE CLAIM

Our office is pleased to help file your claim forms and assist you in getting your claim paid. Our office does NOT guarantee payment by your insurance company. We will make every attempt, at the beginning of your dental care, to receive verification of your policy and an *estimate* of what it covers. However, knowledge of your insurance coverage is your responsibility and time does not always allow us to obtain this information prior to you being seating and electing treatment.

It must be fully understood that our estimate is NOT a guarantee of payment. The contract is between you and your insurance company and that you are fully responsible for any amount not paid by your insurance.

Our office policy regarding insurance assignment:

1. The courtesy of accepting your insurance assignment may be withdrawn if circumstances warrant.

2. If you discontinue care without the Doctor's authorization or do not return to have an emergency procedure completed, the balance of your account is due and payable in full immediately, even if your insurance has been filed. (If the insurance does pay, it will be refunded if you have a zero balance.)

3. Your insurance should pay within 30 days. If your insurance has not paid within 45 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.

4. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

5. In the event that your insurance company pays you directly, your obligation is to send us a check for your dental services immediately upon receipt of the insurance check.

6. All special arrangements regarding finances must be signed by you as the patient/guardian and our Office Manager. This office accepts cash, check (residents of Alamance County), MasterCard, Visa, and Discover as payment.

***If you understand and agree with all of the policies,
please sign your name below and we will submit your insurance claim for you.***

An extended payment plan with 6 months free interest is available through CareCredit only.

PRIMARY INSURANCE INFORMATION:	**SECONDARY INSURANCE INFORMATION:**
NAME OF SUBSCRIBER *PERSON* or POLICY HOLDER:	NAME OF SUBSCRIBER *PERSON* or POLICY HOLDER:
_____	_____
Relationship: Self Spouse Parent	Relationship: Self Spouse Parent
SUBSCRIBER BIRTHDATE:_____	SUBSCRIBER BIRTHDATE:_____
SUBSCRIBER ID/SS #: _____-_____-_____	SUBSCRIBER ID/SS #: _____-_____-_____
SUBSCRIBER'S EMPLOYER:	SUBSCRIBER'S EMPLOYER:
_____	_____
Name of DENTAL Insurance Company:	Name of DENTAL Insurance Company:
_____	_____
Group # : _____	Group # : _____

SIGNATURE of Patient, Parent, or Guardian: _____

DATE: _____