TRINITY DENTAL CARE
INSURANCE INFORMATION

Name of Insured_____ Relationship to insured_____

Birth date of Insured_____ Insured's Social Security_____

Name of Insurance company_____

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Your insurance company is contracted between you and your insurance carrier. **We are not a party to that contract**. We may accept assignment of insurance benefits after we have proper verification. The fees and co-payments for most plans are establisher by your insurance company. **The co-payment and deductible must be paid at the time of service. The balance is your responsibility whether or not your insurance company pays after (90) days.**

Please keep in mind that some procedures have restricted frequencies as to how often they can be performed. As a courtesy, we will call your insurance company so that we can estimate the insurance portion and the patient portion of charges to the best of our expertise This is an approximate computation of probable cost and does not guarantee payment from your insurance company.

I have read and understand and agree to the terms of this financial policy.

Signature of responsible party_____ Date_____