

Palm City Dentistry
Dr. Rene Aviles DMD, PA
870 SW Martin Downs Blvd. Ste:1
Palm City, Fl. 34990
772-283-6881 office

Insurance Authorization & Billing Information

IF YOU DO NOT HAVE DENTAL INSURANCE

☐ Check Box

SIGNATURE X: _____ DATE: _____

Dental Insurance Name: _____ Group#: _____

Subscriber's Name: _____ Patients Name: _____

Subscriber ID or SSN# _____ Subscriber's DOB: ____/____/____

NOTIFICATION TO PATIENTS WITH DENTAL INSURANCE

We are more than happy to work with your dental insurance carrier to maximize your dental benefits. We will gladly file your dental claims as a courtesy to you. Dr. Aviles has elected to participate with certain insurance companies and accept their contracted fees. The insurance policy and/or plan was chosen by you and/or your family member. It is your responsibility to understand the frequencies, clauses, & coverages in your insurance policy/plan. If we are providers, our office will request a basic breakdown of benefits to determine an "approximate" out of pocket co-payment for your dental visit. Please be advised, coverages vary by plan types. It's not guaranteed by your insurance carrier, and you are responsible for all charges, whether paid by your insurance. Amounts not paid within 30 days will incur a monthly finance charge of 1.5%, calculated from the date of service. (18% annual rate). If collection measures become necessary, all related expenses, including agent and/or attorney's fees, will be the responsibility of the patient, parent, or guardian.

The following authorizations are included in all dental/medical billing claims. Because we submit the claims for you, a signature on file must be kept in your record. Please sign the authorizations below.

AUTHORIZATION TO RELEASE INFORMATION:

I have been informed of the treatment for today and associated fees. I agree to be responsible for all charges for dental/medical services and materials not paid by my dental benefits plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____ Date: _____

Signed (Patient, Parent, or legal guardian if minor)

AUTHORIZATION TO PAY BENEFITS TO THE NAMED DENTIST:

I hereby authorize direct payment of the dental benefits otherwise payable to me, directly to Dr. Rene Aviles or Palm City Dentistry.

X _____ Date: _____

Signed (Patient, Parent, or legal guardian if minor)