Cochran, Soares, and Associates
Pediatric Dentistry

Stephen D Cochran, DMD | Flavio M Soares, DDS | Jacqueline M Fetner, DMD

*All are Diplomats of the American Board of Pediatric Dentistry

Patient Name:

Insurance Company Name:

Insurance Company Phone Number:

Insured's Name: Relationship to Patient:

Group Number: Policy ID Number:

Insured's Date of Birth: Insured's Social Security:

Insured's Address: Insured's Employer:

SECONDARY INSURANCE

Insurance Company Name:

Insurance Company Phone Number:

Insured's Name: Relationship to Patient:

Group Number: Policy ID Number:

Insured's Date of Birth: Insured's Social Security:

Insured's Address: Insured's Employer:

OUR FINANCIAL POLICY AND HOW IT WORKS FOR YOU

Whether you are paying with cash or using insurance, you are always ultimately responsible for your bill. We expect payment at the time of service, so please make arrangements to pay when you arrive for your appointments.

OUR RESPONSIBILITIES: We will verify your insurance benefits. We will bill your insurance for you as a courtesy. We will correct any errors we have made when there is a billing dispute. We will provide guidance in getting your bills paid.

YOUR RESPONSIBILITIES: Please know and understand your insurance coverage. Please pay your deductible, coinsurance or copayment at the time of your treatment. Please read and keep your Explanations of Benefits statements from your insurance. Please follow up promptly with claims that are not paid by your insurance company, or you will be billed directly for them.

AUTHORIZATION TO RELEASE INFORMATION I authorize the release of the above provided information and any medical information necessary to: 1) provide for adequate professional coverage in the absence of the primary doctor; 2) to verify insurance a coverage; and 3) to file a claim for insurance benefits related to professional services rendered.

Signature: Date:

(PARENT OR RESPONSIBLE PARTY)

AUTHORIZATION OF ASSIGNMENT OF BENEFITS I authorize direct payment of insurance benefits from to Pediatric Dentistry for professional services rendered.

(INSURANCE COMPANY)

Signature: Date:

(PARENT OR RESPONSIBLE PARTY)