Irvine Dental Group

To Our Patients:

We would like to welcome you to our practice and look forward to providing you with the highest quality of dental care possible. In order to avoid any misunderstandings or misrepresentation, our office would like to inform you of the following guidelines in regards to third party payment and dental insurance plan limitations.

It has come to our attention that members of many HMO and PPO insurance plans are unaware of the terms, limitations, and exclusions of their dental policies. It is in your best interest to familiarize yourself with information such as co-payment or member fee schedules, as well as understand the limitations and exclusions your policy may have. For example, most dental insurances do not cover composite (white) fillings on posterior teeth and will only pay for amalgam (silver) fillings. Patient is thus responsible for the difference between amalgam and composite fillings plus the indicated co-payment of the amalgam filling. Our office will be happy to assist you if you have any queries; however, it may be best to contact your insurance or dental plan directly to clarify any questions you may have. There are hundreds of different dental plans and insurances on the market and we may not be able to answer some questions you may have regarding your particular coverage.

In addition, it is encouraged that you should inquire about co-payments and deductibles due under your plan PRIOR to your treatment. **It is expected that any applicable co-payments or deductibles are due at the time of service**. Our "Pay-at-Desk" policy helps to avoid the high costs of billing, thus keeping your visits less costly.

A broken appointment is a waste for everybody. Please be advised there will be a charge for broken appointments or late cancellations. Twenty four (24) hour notice is required.

Thank you in advance for your cooperation and again, we welcome you to our practice.

I, the undersigned, do hereby declare I have read and understand the policies stated above.

Patient Name: _____ Date: _____

Patient/Legal Guardian Signature: X_____

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