BabyTeeth Children's Dentistry

FOR PATIENTS COVERED BY A DENTAL PLAN

Your dental plan contract is between you and the insurance company. This office may not be a party to that contract. Not all services are necessarily covered benefits in all insurance contracts. Some insurance companies arbitrarily select certain services which are not covered.As a dental care provider, our relationship is with you, not neccessarily with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. Our office is not responsible if your insurance company either denies, or delays payment or is negligent with your payments. In the event that we are a contractual provider with your dental plan, we will extend the reimbursement period for up to thirty (30) days from date of services. At that time, your balance will be charged to your credit card on file unless other arrangements have been made in advance. This time period will not be extended for patients who provide us with incorrect insurance information, fail to keep the information current or fail to fill out the necessary forms, in a timely manner, that their insurance company may request. Submission of insurance clains and/or adjustment of fees may not be done in a retroactive manner.

Although BabyTeeth Children's Dentistry may not directly participate in your dental insurance plans, to help you utilize your insurance benefits, at your request, we may submit a benefits claim form to your insurance company on your behalf. It is our policy to instruct insurance companies to send insurance payments directly to the subscriber. We accept no responsibility in the collection of any insurance claims or in the negotiation of any settlements on disputed claims. In the event we receive any overpayment on your account by your insurance company, we will either credit your account or issue a refund check, when requested.

Please proivde following information about your insurance company:

Subscriber Name: _____

Relationship of Patient To Subscriber: ❑ Child ❑ Spouse ❑ Self ❑ Other

Subscriber S.S.#: _____

Subscriber I.D.#: _____

Insurance/Carrier Name: _____

Group Plan Name: _____

Group Plan Number: _____

Employer Name: _____

Insurance/Carrier Address: _____

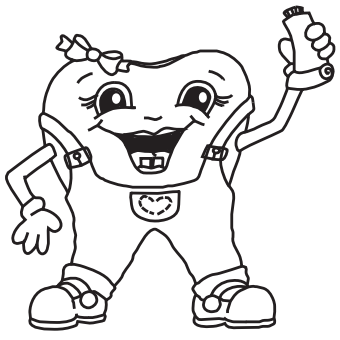
Insurance Tel. #: _____

Payor ID: _____

Effective Date: _____

I have reviewed the treatment plan and authorize release of any information relating to this claim.

Name: _____ Signature: _____ Date: _____



Payman Pirnazar, D.D.S., M.S., Inc.
10921 Wilshire Bvld., Suite 1103
Los Angeles, CA 90024
Tel:(310) 443-9596 • Fax:(310)443-9786
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