Albritton & Ardovino Family Dentistry

Non-Covered Services Policy

As your dentist, I want to provide you with your choice in dental services. There may be certain services that are not covered by your insurance company.

There may be certain services performed in which your insurance will downgrade to a lower paid service. In these cases, you will be expected to pay the fee schedule difference or pay for the service in full. For example, most dental contracts will pay for an amalgam (silver) filling on posterior teeth when a composite (tooth-colored) is indicated or preferred by the patient. Another example is regarding crowns. You may choose a higher end porcelain/gold restoration & any fee from the lab above the PPO or insurance plan fee schedule will be your responsibility.

In addition, most elective cosmetic dental services are not covered by your dental benefits contract. You are expected to pay for these services in full. We only estimate what your insurance will pay and they always given a disclaimer when calling for information that benefits and payment are not guaranteed until a claim is received and processed.

Only services necessary and appropriate for your treatment and care will be performed. We will review all treatment plans with you & give you a printed treatment plan prior to beginning any treatment. If you have any questions, someone in our office will be happy to assist you. Thank you for your understanding and we appreciate you choosing our office to help you with your dental health.

I have read the policy and agree, as indicated by my signature below, to pay for the services above that are not covered or for which payment is not allowed by my insurance contract. I understand that all treatment plans will be discussed with me prior to initiating any treatment & these are estimates.

_____ _____

Patient/Responsible Party Signature Date

Alternative People Communication Authorization Form

There are certain occasions when several people are included in your care as a patient, including family members, friends, or others in which you may want our office to be able to communicate with them directly. In order for us to protect the privacy of your health information, please list, if any, names of other people with whom we can discuss your care and share your health information.

Name:_____ Relation to Patient_____ Phone:_____

Name: _____Relation to Patient_____ Phone:_____

Do we have permission to leave messages on your answering machine or voicemail: _____Yes _____No

Patient Name: _____

Patient Signature:_____ Date:_____