AspenDental®
Let us help you find your smile.

Patient Acknowledgements, Agreements, and Authorizations

I. Treatment Plan Estimates

Aspen Dental prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to Aspen Dental when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change.

If you have dental insurance, it is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate of insurance benefits is based on information provided by your insurance company and by you. In all cases, you are responsible for amounts not covered by your insurance, unless prohibited by law or contractual agreement.

In all cases, we encourage all patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns relating to specific benefits.

II. Predetermination of Insurance Benefits

If you have insurance benefits, you may have the option to seek a Predetermination of Benefits before you proceed with any treatment.

Predetermination of Benefits is a process whereby your insurance company or plan administrator tells you in advance of treatment what procedures may be covered by your insurance plan, the amount the insurance company may pay toward those procedures, and the amount you may be required to pay. Requesting a Predetermination is like submitting a claim before the dental procedure or service has taken place.

Because the Predetermination comes directly from your insurer or plan administrator, the risk of error as to your coverage is reduced. If your treatment includes extensive or complex services, such as bridges, crowns, dentures or periodontal work, a Predetermination may be particularly helpful to allow you to appropriately budget for the services or discuss any potential alternative treatment that may be available, if necessary.

The Predetermination of Benefits process gives you useful information about what services may be covered. However, your insurer will inform you that a Predetermination of Benefits is not a guarantee of coverage. A Predetermination sets forth your expected benefits based on the information available to the insurer at the time the Predetermination is prepared. The Predetermination may not consider, for example, a prior claim submitted by another dentist for services provided to you, changes in your coverage that occur after the Predetermination is made but before the services actually are provided, or the insurance company's subsequent opinion that a condition could have been treated by a less costly alternative to the service provided by your dentist.

The time it takes to receive a Predetermination from your insurance company or plan administrator can vary, from as few as two weeks to as many as eight weeks. The decision to seek a Predetermination of Benefits or to proceed with treatment immediately is your own, unless your plan requires otherwise. **Please inform the Office Manager if you would like to request a Predetermination of Benefits from your insurer**.

III. Payment Policy

In all cases, Aspen Dental patients agree to the following payment policies:

- Payment in full of the estimated patient portion of the fees is due at the time services are provided.

- For comprehensive treatment plans requiring multiple office visits, Aspen Dental requires a minimum deposit of 60% of the total estimated patient portion of the fees at the start of treatment.

- Patients are always responsible for amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit, unless prohibited by law, or unless Aspen Dental has a contractual agreement with my plan prohibiting all or a portion of such charges.

As set forth below in the Refund Policy, any portion of your deposit for services not rendered will be refunded if you choose not to proceed with your full comprehensive treatment plan.

IV. Refund Policy

You may discontinue treatment and ask for a refund from Aspen Dental at any time. Aspen Dental will refund any amount paid for treatment that you did not receive, except when Aspen Dental's policy for Interrupted Denture Services, set forth below, applies.

Refunds will be mailed or transmitted within fifteen (15) business days of our receipt of your request. If you have paid for services not yet provided and do not return to our offices for six (6) months, Aspen Dental will send you a written notice offering a prompt refund of your balance. Refunds will be made in the same manner as the original payment, except that cash payments will be refunded by check.

All requests for refunds should be sent directly to the following:

Aspen Dental Management Inc.
Attn: Refund Processing
P.O. Box 3126
Syracuse, NY 13220

Or email: refundprocessing@aspendent.com

V. Patients with Insurance

Aspen Dental's Payment Policy, stated above, applies to all patients, including those with insurance, subject to the following:

A) In Network

If Aspen Dental is a participating provider in your plan network, your insurer may impose on Aspen Dental requirements that can impact your obligation to pay. For example, Aspen Dental may be required to receive approval from you in advance of treatment for non-covered services or may charge you only your co-payment at the time covered services are provided. In all cases, Aspen Dental will bill you pursuant to the terms of its agreement with your insurer.

B) Out of Network

Even if we are not a participating or in-network provider with your insurance plan, we may still work with your plan on an out-of-network basis if you assign benefits to be paid to Aspen Dental. Aspen Dental will reduce your payment or deposit by your estimated insurance benefit, but you must assign the benefits to be paid for dental services to Aspen Dental. If the insurance plan will not pay benefits directly to Aspen, you will bear full financial responsibility for your treatment plan, according to our payment policy.

C) Insurance Discounts

Insurance companies often negotiate discounts with Aspen Dental for services provided to their plan members. Aspen Dental will charge additional services at the discount rate even after the insurance benefit has been exhausted when the agreement between your insurer and Aspen Dental so requires.

VI. Interrupted Denture Services Changes

Patients requiring dentures may cancel their dentures at any time during the fabrication process prior to the completion of your dentures. If you choose to cancel prior to completion, you will be charged $100 per visit for each step in the fabrication process, not to exceed $300, depending on how many steps have been completed. Once your denture is fabricated, you are responsible for its full fee.

VII. Accepted Forms of Payment

Aspen Dental accepts cash, personal checks, Visa®, MasterCard®, American Express®, Discover®, assigned insurance benefits and approved third-party financing.

VIII. Third-Party Financing

Aspen Dental offers treatment financing through third-party lenders, such as CareCredit® and ChaseHealthAdvance®. Aspen Dental pays these companies fees on a sliding scale for making loans available to its patients and for servicing these loans. As the aggregate amount of care financed through these lenders increases, the fees they charge Aspen Dental decrease. This sliding-scale pricing arrangement does not affect your loan amount or the cost of your treatment.

IX. Patient Satisfaction Contact Information

Aspen Dental is committed to providing all patients with exceptional service and care. If you feel you have an issue that cannot be resolved by the Aspen Dental office you visited, please call our Patient Satisfaction Hotline at 1-866-273-8606 or email us at patientservices@aspendent.com. We will respond to you as quickly as possible, always within two business days from your initial contact with us. Aspen Dental is committed to your total satisfaction and we look forward resolving any issues quickly and courteously.

1. Notice of Privacy Practices (must be signed by ALL new patients.)

By signing below, I acknowledge that I have read Aspen Dental's Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature____Date____________________
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

2. Payment, Insurance, and Financial Arrangement Policies (must be signed by ALL new patients.)

By signing below, I acknowledge that I have read, understand and agree to the terms of the attached Aspen Dental Insurance and Financial Arrangement Policies. I acknowledge that I have been informed of the treatment plan and estimated fees. I agree to be responsible for all charges for dental services not paid by my dental insurance plan, unless prohibited by law, or unless Aspen Dental has a contractual agreement with my plan prohibiting all or a portion of such charges.

Signature____Date____________________
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

3. Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance.)

To the extent permitted by law, I consent to Aspen Dental's use and disclosure of my protected health information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment of the dental benefits otherwise payable to me directly to Aspen Dental.

Signature: ____Date: __________________
(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

Responsible Party (If patient is under 18 or disabled)

Circle One: Dr/Mr/Mrs/Ms/Miss

First:____________________Middle:____________ Last:____________________________________Jr/Sr:______

Street: ____City:__________________ State: ______Zip: __________

Home Phone: (____) ________________Work Phone:(____) _____________Cell Phone:(____) _____________

Patient SSN: _________-________-_________Patient Date of Birth: _____/_____/_____Sex:(circle) **M F**

Signature:____Date:__________________