

PUEBLO DENTAL CENTER

1000 N. Silverbell Road Tucson, AZ 85745 520-624-7514

Authorization for Signature on File Authorization of Payment

Pueblo Dental Center is happy to accept most insurance plans and, as a courtesy will process your paperwork for you. We will bill your insurance carrier for our Usual and Customary Rates (UCR) related to your care. Our Doctors are contracted providers for most major PPO insurance plans, and as such, we honor the discounted fees for those plans and try to accurately estimate your patient portion with the information provided to us. From time to time, without our knowledge, insurance carriers adjust their procedural fees resulting in an increase or decrease in your patient portion. Debit or credit PPO adjustments in billing will reflect these changes in fees which were set forth by your insurance company. At no time will the total charges exceed the contracted fees for the services provided.

To process your claims and to receive payments directly from your insurance company, we will need an authorized signature to keep on file. In this case, only your estimated patient portion is expected at the time of service. Pueblo Dental Center, at our Silverbell location also offers **Medical billing** for certain Dental procedures covered under both Dental and Medical insurances.

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. **Process all insurance claims;**
2. **Ensure payment for services provided;**
3. **Release dental/medical information to insurance companies needed for the processing of your claims**
4. **Release information to other dental and medical providers, including laboratories, when necessary, for your treatment.**

____ I hereby authorize Pueblo Dental Management, Inc. to affix my name and/or my dependent's name to any and all claims or documents, to the extent permitted under applicable law, as related to any and all Dental benefits due me through my Dental and Medical Plan(s). I also authorize payment of Dental Benefits, otherwise payable to me from my insurance company, to be paid directly to Pueblo Dental Management, Inc.

____ I hereby authorize the release of all Dental and Medical information necessary to process my claims and to release the same information, when necessary, to other providers and labs rendering Dental/Medical care that need my information to make, diagnosis, or fabricate an appliance necessary for my treatment.

If you decide that you wish to process your claim yourself, without our assistance, and to be reimbursed directly from the insurance company, then payment in full will be expected when you check in for your appointment.

____ ***I will process my claim without the assistance of Pueblo Dental Center. I understand that, by making this choice, I will be responsible for paying in full the fees that Pueblo Dental Center would have received from both myself and my insurance company for the services provided.***

Signature

Date

Parent or Legal Guardian (Please print)