BabyTeeth Children's Dentistry

FOR PATIENTS COVERED BY A DENTAL PLAN

Your dental plan contract is between you and the dental plan/insurance company. This office may not be a party to that contract. Not all services are necessarily covered benefits in all dental plan/insurance contracts. Some dental plan/insurance companies arbitrarily select certain services which may not be covered.

As a dental care provider, our relationship is with you, not neccessarily with your dental plan/insurance company. While the filing of dental plan/insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. Our office is not responsible if your dental plan/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/insurance, 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 dental plan/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 dental plan/insurance claims 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 plan/insurance, to help you utilize your dental plan/insurance benefits, at your request, we may submit a benefits claim form to your insurance company on your behalf. In this case, it is our policy to instruct dental plan/insurance companies to send reimbursement payments directly to the subscriber. We accept no responsibility in the collection of any dental plan/insurance claims or in the negotiation of any settlements on disputed claims. In the event we receive any overpayment on your account by your dental plan/insurance company, we will either credit your account or issue a refund check, when requested.

The following information will be used to submit your claim to your dental plan/insurance company:

DENTAL PLAN INFORMATION

Subscriber Name: _____

Relationship of Patient To Subsciber: _____

Subscriber S.S.#: _____

Group/Policy #: _____

Employer Name: _____

Insurance Company: _____

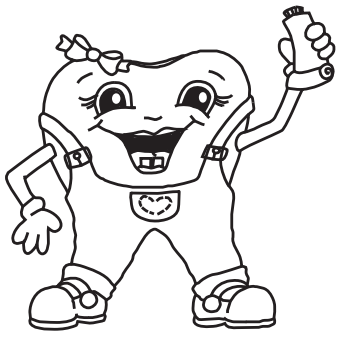
Insurance Tel. #: _____

How long have you had this dental plan/insurance? _____

In order to comply with most dental plan/insurance companies, we ask that you sign below so that we may keep your signature on file. Treatment plans are never submitted without your approval.

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

Name: _____ Signature: _____ Date: _____



Payman Pirnazar, D.D.S., M.S., Inc.
11620 Wilshire Bvld., Suite 720
Los Angeles, CA 90025
Tel:(310) 443-9596 • Fax:(310)443-9786