

FINANCIAL POLICY

At Parkway Periodontal Group, our doctors and staff are proud to be a team whose primary mission is to deliver the finest and most comprehensive periodontal services available. We are concerned about your dental care that is performed in the most responsible manner.

INSURANCE SUBMISSION

As a courtesy to you, Parkway Periodontal Group will file your benefit insurance claims on your behalf. Please advise us of any insurance changes and provide us with accurate dental insurance plan prior to service. You are responsible for knowing your insurance coverage and limitations of your plan. Insurance for periodontal procedures can vary significantly depending on the specific service, employer coverage, and insurance plan.

For some services an insurance pre-authorization is recommended, through which we can submit the recommended treatment plan to the insurance company for a written verification form of the extent of coverage. Wellmark Blue Dental, Blue Cross of Iowa, and Federal Blue may pay their subscribers for periodontal benefits. If you do receive an insurance check, you can cash them as you receive them. Please be aware we are not a Medicare or Medicaid providers. We are able to process and file only Medicare supplement insurance plan claims.

PAYMENT

You are fully responsible for your account. Payment is expected prior to the day of services for surgical procedures and subgingival scaling and root planing. For your convenience, payments may be made with MasterCard, Visa, personal checks or cash. If you cannot meet this payment schedule, please visit with the front desk personnel to discuss your financial situation.

Care Credit

Care Credit is another alternative to help facilitate your care. It creates special financing options related to your treatment needs. Our front office team members would be happy to help answer questions regarding CareCredit.

If you have any questions, please ask our front office staff. They are well informed and up-to-date. Please do not hesitate to reach out to us regarding your visit.

I agree to the above terms and conditions and assume full responsibility for insurance coverage and limitations. I have read and understand the financial policy of Parkway Periodontal Group.

Patient Name (please print): _____

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY
