INSURANCE AUTHORIZATION

At **Terry H. Vibbert, D.D.S., P.C.** (The Village Dentist) we want to help you maximize your dental insurance benefits to allow you to have the best dental care possible. That is why we have developed two ways to make it easier for you.

Please take a moment to tell us how you would like us to work with your dental insurance benefits.

☐ **I prefer to receive a 5% bookkeeping courtesy by paying in full at the time of my visit.**
Please take care of all the paperwork for my dental insurance company and have them send the reimbursement check directly to me.

☐ **I prefer to pay my estimated co-payment by cash, check, or charge card at the time of my visit.**
Please take care of all the paperwork and have my dental insurance company reimburse you. I authorize you to charge any delinquent balance to my credit card on file.

Insurance Carrier_____ Employer_____

Subscriber Name_____Subscriber ID_____

Subscriber Date of Birth_____ Group #_____

Insurance Address (Claims Address)_____

City_____ State_____ Zip Code_____Phone_____

Insurance Benefits

I understand that I have chosen to assign my dental benefits to **Terry H. Vibbert, D.D.S., P.C.** and a claim form along with documentation will be sent to my insurance company for treatment provided. I understand that I am ultimately responsible for this payment regardless of my insurance company's willingness to pay a benefit for this claim.

Appointment Changes

In an effort to keep timely appointments, our office does not double book appointment times. Our time is reserved and dedicated solely to you and you will seldom, if ever, have to wait. Because of this, changes and cancellations to our schedule are catastrophic.

We ask that any cancellations or changes to your appointments be made at least 24 hours prior to your scheduled appointment. If we are not notified 24 hours prior to your appointment, then we may regrettably charge your account. Missed appointments are charged $40 for hygiene appointments and $100 for doctor appointments.

I hereby authorize **Terry H. Vibbert, D.D.S., P.C.** to keep my signature on file and to charge my credit card for any delinquent account balance I have not paid. I understand that as a courtesy, any account credits will also be refunded back onto my credit card account and every effort will be made to advise me prior to either.

☐ MasterCard ☐ Visa ☐ Discover

_____

Credit Card Account # Exp. Date

_____

Cardholder's Signature