Brian O. Coleman, D.M.D., P.A.
Ωmega Dental Group
Tangerine Professional Center
7200 Aloma Avenue, Suite D
Winter Park, Florida 32792
(407) 671-1017

AGREEMENT

As a courtesy to you, our patient, we will file your dental insurance claim forms with the following provisions. It is important to understand that the contract regarding your dental benefits is between you, your employer and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company, as it is always an ESTIMATE.

- Payment is due at time of services. We require you to pay the ESTIMATED co-payment at the time service is provided or the entire amount if self-pay.
- Please inform us of any insurance changes 24 hours prior to dental appointment, or you will need to prepay at time of services and file the insurance on your own.
- Though insurance payments are ordinarily received within 30-60 days, if your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance due. At 90 days, it will be referred to a collection agency.
- Regretfully, if you are late for an appointment, we may have to shorten your treatment time in order to be on schedule for our next patient.
- $50 per hour may be charged for appointments not cancelled within 24 hours.
- We accept cash, check and all major credit cards. We offer outsource financing with approved credit that includes interest-free and extended payment plans. You may visit Carecredit.com to apply.
- After one statement is sent, if balance is not paid within 30 days, there may be a rebill fee of $25 added to second statement. Payment is due upon receipt.
- An insurance company may down-grade any procedure, such as posterior fillings-we only do resin composite fillings (white)-some plans still only pay for amalgam (silver). After insurance, pays, you will be billed the difference.

I understand that the information that I have given the office is correct to the best of my knowledge and will be held in strict confidence. It is my responsibility to inform this office of any changes. I authorize the dental staff to perform any necessary dental services that I may need with my informed consent.

I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE PROVISIONS. I authorize the office of Brian O. Coleman, D.M.D., P.A. to release any of my medical information to my insurance company as needed, to process my insurance claim. I hereby authorize my insurance company to pay dental benefits directly to the doctor. I authorize Dr. Coleman's office to file my insurance claims electronically.

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Signature of Patient or Responsible Party Date