

**Dufferin Vaughan Dental Centre**  
**1611 Rutherford Road, Unit 2**  
**Vaughan, ON L4K 0C6**  
**905.303.7331**

**OUR OFFICE POLICY REGARDING DENTAL INSURANCE**

In order to make your dental visit more convenient, our office offers to bill your insurance directly. However,

- Keep in mind that the doctor does not have a contract with the insurance companies, **YOU DO!**
- Any deductible and /or co-payment are due upon treatment.
- Although we try our best to keep within your insurance coverage, this may not always be possible. Insurance companies do not give us every little detail on dental policies, therefore we cannot guarantee that all treatment rendered will be fully covered.
- Please note that some insurance companies have a non-assignment policy, which means that they **DO NOT** send cheques directly to the dentist. Patients with such policies are required to pay at the time of their appointment.
- Our office does not give a discount for any amount that is not covered by your insurance. For example, if you are covered at 80%, we cannot write off the 20%. This is your balance and you are required to pay this at the time of your appointment. It is considered insurance fraud if we write off the difference.
- If you want us to receive payment from a third party (Your Insurance Company) we will accept the assignment of fees, but we need authorization from you to allow us to receive payment from your insurance company. We also require authorization from you to allow us to supply the insurance company with any information they may require pertaining to any claims we submit on your behalf. This may include forms such as progress notes, charting, radiographs, etc.
- Please inform us immediately of any changes to your insurance policy, your home address and phone numbers.

**I \_\_\_\_\_, have read and understood the above information and had the opportunity, to ask questions and receive answers. I understand that responsibility for payment of the dental services for my dependents and myself is mine, and I assume responsibility for fees associated with these services.**

**I/WE AUTHORIZE DUFFERIN VAUGHAN DENTAL CENTRE TO RECEIVE PAYMENT FROM MY/OUR INSURANCE COMPANY DIRECTLY.**

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Patient/Parent/Guardian Signature

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Date

**(Please fill out your name and the date in the boxes above, then save the file and email back to us at [dvdentalcentre@gmail.com](mailto:dvdentalcentre@gmail.com))**