GLENN L. SANDS DDS
COSMETIC AND FAMILY DENTISTRY
1770 E. Ft. Union Blvd, Ste 201 Salt Lake City, UT 84121 801-942-0810 glennsandsdds@hotmail.com

To our valued patients, please initial each blank below:

____ Due to extensive and sweeping changes in the health care insurance industry, we are no longer able to obtain accurate information from your insurance company on your benefits.

____ Therefore, we can only provide you with an estimate of your insurance coverage and your co-pay (the amount you will be responsible to pay). We file your insurance as a courtesy to you and suggest that you would also call your insurance company to verify your benefits and coverage.

____ If the estimate of your responsibility is too high, you will receive a refund from us.

____ If the estimate of your responsibility is too low, we will send you a bill for the remaining balance which you will be responsible to pay.

____ If your insurance company denies the claim, **even if they initially gave us an approval but then rescinded their approval**, or the insurance company will not cover any of the services provided to you for whatever reason, we will send you a bill for the remaining amount of the services you received which you will be responsible to pay.

____ The following is a special consent required for upgrades. Some insurances only pay on materials that we feel are of a lesser quality. Please refer to your dental policy to see if this applies to you. Dr. Sands wants to provide you with the best quality care which includes a higher quality material that may not be covered by certain insurances. The difference in cost of material is passed on to you

We appreciate your understanding of these circumstances which are beyond our control. Our relationship is with you, the patient, and not with your insurance company. We will do everything in our power to make your experience with us as comfortable and economic as possible.

Sincerely,
Dr. Sands & Staff

_____
Patient signature (or parent if minor)

_____

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Date