FIRST AVENUE DENTAL, PA 74 SE 1st Avenue Little Falls, MN 56345
Dr. S. A. Olson D.D.S

PATIENTS WITH INSURANCE:

1. To get the best possible benefit from your insurance, please bring the proper referrals, cards and forms with you to your first visit

2. Dental insurance is an area that creates confusion for many dental patients. The complexities of dental insurance and the lack of sufficient information provided by some insurance companies make it difficult for some patients to properly understand their benefits. At First Avenue Dental we will do everything possible to help you understand and make the most of our dental insurance benefits.

3. Please be aware that some dental insurance companies take longer than others to complete payment. If necessary, our office will contact the dental insurance company, or we may request your help in this matter.

4. We are a provider on several different insurance plans and as a courtesy, we are happy to file your insurance claim. Please understand that every insurance policy pays benefits based on their own fee schedules. It is impossible for us to know every insurance fee schedule and their limitations. We are always willing to assist you in anyway we can, but realize it is the patients responsibility to know and understand their insurance benefits.

5. In cases where there is a primary and secondary insurance, we will follow the insurance company's determination as to who is the primary and who is the secondary. We expect you to know these conditions before your visit.

6. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible, co-payments, and co-insurance at the time of service. You are responsible for paying all charges not covered by your insurance company.

THANK YOU FOR YOUR HELP!

SIGNATURE____**DATE**___________________________

PRIMARY INSURANCE

NAME OF POLICYHOLDER____

RELATIONSHIP TO
PATIENT____________________BIRTHDATE___________________SSN#__________________________________

NAME OF EMPLOYER____WORK PHONE_______________________

INSURANCE
COMPANY____GROUP#______________ID#:_____________________

INS. CO. ADDRESS____

SECONDARY INSURANCE

NAME OF POLICYHOLDER____

RELATIONSHIP TO
PATIENT____________________BIRTHDATE___________________SSN#__________________________________

NAME OF EMPLOYER____WORK PHONE_______________________

INSURANCE COMPANY__________________________________GROUP#____________ID#_____________________

INS. CO. ADDRESS____