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 be aware that insurance companies are all different and do not provide us with all of the information necessary for us to give you an exact amount for each procedure. We usually are provided with a fax with the information that THEY feel necessary. We do our best to give you the best ESTIMATE possible.

- 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.

- Regretfully, if you are late for an appointment, we may have to shorten your treatment time in order to be on time 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.

- 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). A crown may be downgraded to metal, etc. After insurance, pays, you will be billed for the difference.

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