Travis Q. Harshman, DDS, PC
SPECIALIST IN ORTHODONTICS
Trusted, experienced care, for a lifetime of beautiful smiles

FINANCIAL POLICY

We are committed to providing you with the best possible orthodontic care. We also want to serve you in a manner that is as comfortable and pleasant as possible. In order to achieve these goals, we need your assistance and your under standing of our payment policy. We will gladly discuss your proposed treatment, give you as detailed an estimate as possible in writing, and answer any questions that we can about your insurance. If you have orthodontic insurance, we will assist you in receiving your maximum allowable benefits.

We cannot emphasize too strongly that the extent of your insurance benefits is defined in a contract between you, your employer, and an insurance company. We are not a party to that contract. As your orthodontic care provider, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We will help you by processing your insurance claim form and sending it in promptly. Payment can be made with cash, check, Visa, MasterCard or Discover.

We realize that a temporary financial crisis may affect timely payment of your account. If such a crisis does develop, we encourage you to contact our office immediately for assistance in redefining the payment terms of your account. By keeping the lines of communication open, we can avoid any misunderstandings that would interfere with our positive relationship.

Patient Name: _____ Date of Birth: _____

PRIMARY Dental Insurance

Orthodontic Coverage? ___Yes ____No

Insured's Name:_____

Relationship to Patient: _____

Insured's SS# / Contract #: _____

Insured's Birth Date: _____

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Group#: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

SECONDARY Dental Insurance

Orthodontic Coverage? ____Yes ____No

Insured's Name: _____

Relationship to Patient: _____

Insured's SS# / Contract #: _____

Insured's Birth Date: _____

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Group#: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

For office use only

Date Verified: _____

Initials: _____ Contact Name: _____

Coverage: _____% Lifetime Maximum $: _____

Age Limit: _____ Amount Used to Date $: _____

Assign. Of Benefits: ____Yes ____No Deductible: ___

Payments: _____Auto or _____Send Forms:_____Mnthly_____Qtrly

PRIMARY Amount Remaining: $ _____

Date Verified: _____

Initials: _____ Contact Name: _____

Coverage: _____ % Lifetime Maximum$: _____

Age Limit: _____ Amount Used to Date $: _____

PAYMENT TO SUBSCRIBER deductible: _____

Payments:_____Auto or_____ Send Forms:_____Mnthly____Qrtly

SECONDARY Amount Remaining: _____