FINANCIAL AGREEMENT

Thank you for choosing us to provide dental care for you and your family. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know what our expectations are in the area of finances before you begin treatment. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our office staff.

DENTAL INSURANCE

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following.

- You must provide us with an insurance card and all the information necessary to verify you and your families' coverage.
- Your insurance policy is a contract between you, your employer and the insurance company. We are **NOT** a party to that contract. Our relationship is with **YOU** and not your insurance company.
- You are responsible for our fees and not what the insurance company allows or considers "usual, customary and reasonable" which can vary from one company to another.
- Although we may estimate your insurance benefits we are **NOT** responsible for their accuracy. Knowledge of benefits, benefit amounts, limitations, exclusions, waiting periods, etc. is entirely **YOUR** responsibility. **Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.**
- A statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.
- All charges not paid by your insurance company are **YOUR** responsibility regardless of the reason for non-payment. Some services we provide may not be a covered benefit on your policy. Benefits vary for each policy. **FEES FOR NON-COVERED SERVICES, ALONG WITH DEDUCTIBLES AND CO-PAYMENTS ARE DUE AT TIME OF SERVICE. ANY BILLING DECREPANCIES MUST BE SETTLED WITHIN 30 DAYS OF THE FIRST BILLING DATE.**

PATIENTS WITHOUT INSURANCE COVERAGE

We will provide an estimate of the cost for the treatment discussed. When treatment is scheduled we will do our best to estimate what is due at each time of service. However things can change during on-going treatment where we will then refigure your payments due at each visit. At any time if you have questions or concerns do NOT hesitate to ask. Once you agree to the treatment and the work is completed the bill is **YOUR** responsibility. **ANY BILLING DECREPANCIES MUST BE SETTLED WITHIN 30 DAYS OF THE FIRST BILLING DATE.**

PAYMENTS ACCEPTED

- Cash, Personal Checks, Debit Cards, Visa, MasterCard and Discover.
- We also offer **Care Credit!!** Ask us how to apply if interested

PLEASE CONTINUE TO THE BACK PAGE

MINOR PATIENTS

The parent or guardian accompanying the minor is responsible for full payment. If someone else is bringing the child we need to have your permission to discuss treatment and or approve of treatment needing to be done in the office that day by that adult. At that time we can also let you know the copay so the adult bringing them can be prepared.

RETURNED CHECKS: A $25.00 charge applies when a check is returned by the bank.

FINANCE CHARGES AND REBILL FEES

A finance charge or rebill fee will be applied to all balances not paid within 60 days of the monthly billing date. A late charge of **1.5% on the balance then unpaid or a 3.00 fee for rebill (the higher of the two)** will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges. **ANY BILLING DECREPANCIES MUST BE SETTLED WITHIN 30 DAYS OF THE FIRST BILLING DATE.**

OVER DUE BALANCE

An account with an unpaid balance past 90 days will be sent to the 77th District Court for collections. At this time you are agreeing to pay collection costs, attorney fees, court fees and any other fees incurred in attempting to collect this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to **communicate** any such problems immediately so we may assist you in the management of your account. **ANY BILLING DESCREPANCIES MUST BE SETTLED WITHIN 30 DAYS OF THE FIRST BILLING DATE.**

BROKEN OR MISSED APPOINTMENTS

A broken appointment is when you do not give us a 24 hour notice if you need to cancel or change your appointment. **WITHOUT A 24 HOUR NOTICE AS OF JANUARY 01, 2018 THERE WILL BE A $50.00 FEE ADDED TO YOUR ACCOUNT.** There will be no more appointments scheduled until that $50 is paid. If you acquire **TWO** broken appointments we will then be informing you (by letter or verbally) that if this problem continues we will have to terminate our doctor/patient relationship. **THREE** broken appointments will automatically result in termination of our doctor/patient relationship, at that time we will send out a letter informing you of this decision. In that letter there will be a release of record consent form you can fill out and return to our office when you have found a new dentist. We reserve the right to terminate our doctor/patient relationship at any time should we feel it is in the best interest of our patients and the office.

RECORDS

Original records including radiographs are the property of this office. If you desire we will provide you with a copy of you and your families' records or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION

I authorize dental treatment on myself or my child and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Gingrich Dental PC. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:
Name_____Signature_____
If you are filling this out for a child, are you the person legally responsible Yes_____No_____

Relationship to patient _____ Date_____

Reviewed by staff member_____Date_____