GIFFORD
FAMILY DENTISTRY
Gentle • Friendly • Trusted

# *Financial Policy*

Thank you for choosing Gifford Family Dentistry. Our team takes pride in providing every patient with the best possible dental care. We want you to feel as comfortable as possible throughout your treatment. This includes understanding your treatment plan as well as our financial policy.

## *Do You Accept My Insurance? How Much Will They Pay?*

We currently work with most private dental benefit plans. The amount of coverage that your benefit plan provides is negotiated between your employer and the insurance company. Payment of benefits for provided treatment is never guaranteed by the insurance companies. Therefore, it is impossible to give you a guaranteed quote prior to or at the time of service, even if the services are preauthorized. We estimate your portion based on the most up-to-date information we have, but it is still only an estimate. We will **always** make a diligent effort to collect the full portion due from your insurance company. We accept and bill your insurance claiming assignment of benefits. What this means is your insurance will pay our office directly and we will apply it to your claim accordingly. If your insurance does not accept assignment of benefits and pays you directly, it is your obligation to forward that payment to our office to assign their portion of the claim. **PATIENT INITIALS:**

## *My Insurance Did Not Pay Now What?*

Please keep in mind that a dental benefit plan is a contract between you, your employer, and the insurance company. We will bill your insurance company as a courtesy to you; however, while we will attempt to help you understand your plan, it is your obligation to know your insurance plan, exclusions, limitations, and ultimately pay for any treatment your insurance company refuses to cover. **PATIENT INITIALS:**

## *Minor Patients*

The adult(s) accompanying a minor and the parent(s) (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time the service has been verified. In the case of pending divorce or separation, the party responsible for the account prior to the divorce or separation remains the responsible party. After a divorce or separation, the parent authorizing the treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We are unable to place a parent or guardian on an account, as the responsible party, without the express, written authorization from that parent. **PATIENT INITIALS:**

## *Financial Responsibility*

**Your estimated portion is due at the time of service.** We accept cash, checks, Visa, MasterCard, and Care Credit. ***Finance Charges:*** All severely past due balances (60 days and greater) are subject to finance charges of 12% APR, or a minimum of $5 per month. This is to offset the costs associated with repeated billing of statements.
**Late Arrivals and Broken Appointments:** Please give us a courtesy call if you are running late. We trust that our patients make every effort to honor the day and time reserved for them, and we strive to run on time out of respect for every patient on the schedule. Late arrivals and broken appointments harm a dental practice's ability to be successful. Please provide at least 2 business days advance notice if you want to reschedule your reserved time. Our business days consist of Tues-Fri. A $150 fee may be charged for appointments missed or broken with less than 2 business days advance notice. Extenuating circumstances are considered. Repeat offenses may result in dismissal.
**I am financially responsible for all charges.** If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. **PATIENT INITIALS:**

**Patient Name:** ______________________________ **Date**____________

**SIGNATURE & PRINTED NAME OF RESPONSIBLE PARTY:**_______________________________________________