

**Financial Policy/Dental Insurance Coverage Notice and Disclaimer-Please initial:**

**Dental Insurance**

\_\_\_\_\_Our office participates with most dental plans. If you have dental insurance, we will submit all claims as a courtesy, even if we aren't an in network provider. We will wait for your insurance company to pay their expected portion. I further understand that I will be responsible to pay my estimated copay at the time of service, and for any and all amounts not paid or covered by my dental insurance after payment is received.

If you do not have any dental insurance coverage, payment is expected in full at the time of service. Payment options are available. We do accept: Cash, Check, Debit, Visa, Mastercard, Discover, American Express, Care Credit, Compassionate Finance.

\_\_\_\_\_I realize that such charges will include but may not be limited to amounts incurred from deductibles, co-payments, and amounts not covered by my dental insurance due to ineligibility/yearly/lifetime maximums of my benefits.

\_\_\_\_\_If you/we have a question about insurance coverage, we can submit a predetermination of benefits to your insurance company so that you can have an insurance estimate of the amount you will be responsible for. Insurance companies typically take 30-90 days to process predeterminedations.

\_\_\_\_\_I understand and agree that Gentle Family Dentists does not represent my dental insurance company and that Gentle Family Dentists cannot make ANY representation or warranty that my dental insurance company will cover all or any portion of the dental services provided by Gentle Family Dentists.

\_\_\_\_\_I acknowledge that it is my ultimate and sole responsibility to determine whether a dental service, procedure, or treatment program is covered by my dental insurance, and if covered, the amount of coverage that will be provided and whether my benefits are exhausted or will be exhausted during the service, procedure, or treatment program. I further confirm that any statement made by anyone at Gentle Family Dentists concerning my dental insurance coverage cannot be relied upon as a guarantee of coverage.

**Returned Payment**

\_\_\_\_\_If for any reason payment is returned there will be a \$30.00 additional charge for each returned check. If it is necessary to place your account with a collection agency, you or the guarantor will be responsible for ALL collection costs, reasonable attorney fees, and court costs.

**Discounts Offered**

Gentle Family Dentists offers a 5% senior discount(60 and older), as well as a 5% pre-payment discount for all services paid in full 1 week before appointment date(either/or). A 10% discount is offered for orthodontic services paid in full 1 week before orthodontic records appointment(ask our front office team about our other financing options for braces/invisilign).

**Our Policy for Late Arrival and Broken/Canceled Appointments**

\_\_\_\_\_Our relationship with our patients is one of reciprocity. We strive to give you the quality dental and health care that you expect. To provide these services, our patients must attend their appointments as scheduled. We reserve the right to reschedule your appointment if you arrive late. An appointment is considered broken when a patient fails to

attend. Please let us know if there is anything more we can do to further assist you.

**Retroactive Insurance Coverage**

\_\_\_\_\_Occasionally, insurance coverage will be granted for services already completed. We as an office will file pre-authorizations and insurance claims for these companies and reimburse any funds to the party that paid for the service after insurance claims have been paid and completed (typical time frame 30-90 days)

If you would like to keep a copy of this agreement, please let the front office personnel know and a copy will be provided for you.

I understand the FINANCIAL POLICY/DENTAL INSURANCE COVERAGE NOTICE AND DISCLAIMER and OUR POLICY FOR LATE ARRIVAL AND BROKEN/CANCELED APPOINTMENTS, and agree to abide it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name(s): \_\_\_\_\_ Legal Guardian: \_\_\_\_\_