GAGE CENTR DENTAL GROUP, PA
FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. YOUR CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY, OR YOUR RESPONSIBILITY.

ALL CO-PAYMENTS ARE DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS

1.) **IF INSURANCE IS INVOLVED, CO-PAYMENT AND ANY DEDUCTIBLE IS TO BE PAID AT THE TIME SERVICES ARE RENDERED.**

2.) THE PARENT OR GUARDIAN WHO ACCOMPANIES A MINOR TO THE APPOINTMENT IS FINANCIALLY RESPONSIBLE FOR THE ACCOUNT.

3) WE REQUIRE 24 HOURS NOTICE FOR ANY CHANGE OF APPOINTMENT. FAILURE TO COMPLY MAY RESULT IN A MISSED APPOINTMENT FEE.

4.) A 1.5% PER MONTH CHARGE WILL BE ADDED TO CHARGES ON ACCOUNTS NOT PAID WITHIN SIXTY DAYS AFTER THE DATE OF TREATMENT. THIS PERIODIC RATE EQUALS AN **ANNUAL PERCENTAGE RATE OF 18%.** IN THE EVENT OF A DEFAULT THE PATIENT WILL PAY ALL COLLECTION CHARGES AND/OR ATTORNEY FEES TO RECOVER UNPAID BALANCE. _______**INITIAL**

WE FILE INSURANCE AS A COURTESY TO OUR PATIENTS IF CURRENT INFORMATION IS PROVIDED TO US. INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOUR BENEFITS DEPEND ON WHAT YOU OR YOUR EMPLOYER NEGOTIATED WITH THE INSURANCE CARRIER. IT IS IMPOSSIBLE FOR US TO HAVE COMPLETE KNOWLEDGE ABOUT THE NUMEROUS DENTAL AND MEDICAL INSURANCE COMPANIES CONTRACTS WITH EMPLOYERS OR YOUR STATUS WITH YOUR PARTICULAR COMPANY. PLEASE NOTE THAT MANY INSURANCE COMPANIES DO NOT PROVIDE THEIR ALLOWED FEES UNTIL AFTER TREATMENT IS COMPLETED OR A WRITTEN
PRE-AUTHORIZATION IS RECEIVED FROM YOUR INSURANCE COMPANY. THIS CAN SOMETIMES MAKE IT DIFFICULT TO ACCURATELY ESTIMATE YOUR INSURANCE CO-PAYMENT BEFORE TREATMENT IS RENDERED.

UPON RECEIPT OF AN INSURANCE PAYMENT, ANY REMAINING BALANCE IS BILLED TO YOU. A REFUND IS ISSUED WHEN YOU HAVE A CREDIT BALANCE RESULTING FROM A PATIENT OVERPAYMENT.

WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED CHARGES, SECONDARY INSURANCE, OR OTHER MATTERS REGARDING REIMBURSEMENT. IF ACTION BECOMES REQUIRED TO COLLECT A DEBT, YOU WILL BE RESPONSIBLE FOR ANY AND ALL COURT COSTS INCURRED IN THE PROCESS.

I UNDERSTAND I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT REGARDLESS OF WHAT MY INSURANCE CARRIER MAY OR MAY NOT PAY. THIS SIGNATURE WILL ALSO SERVE AS SIGNATURE ON FILE FOR ASSIGNMENT OF INSURANCE BENEFITS. I AUTHORIZE RELEASE OF INFORMATION RELATING TO INSURANCE CLAIMS.

PATIENT /GUARANTOR SIGNATURE______________________________ **DATE**______________