# Our Office Financial Policy

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

**Regarding Insurance Filing**

Please be advised that our office DOES NOT guarantee insurance benefits. Your insurance is a contract between you, your insurance company and, in some cases, your employer. Please note the following about your insurance:

- Insurance is billed as a courtesy to the patients of Garners Ferry Dentistry.
- We will make every attempt to verify and quote your insurance coverage to you accurately. This expected insurance payment is only an ESTIMATE and is not a guarantee of what your insurance company will pay.
- Depending on your plan, you may be required to pay for our services out of pocket and seek reimbursement directly from your insurance company. You must notify us of any change in insurance.
- As the patient/insured you agree to be responsible for any amount not paid by your insurance company for any reason including any portions denied or unpaid or downgrades to an alternate acceptable treatment.
- Any co-payments, deductibles, and any services not covered by your insurance plan must be paid at the time the service is provided unless other arrangements are made.
- The balance is your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 55 days, the balance will be automatically transferred to your account.
- We are not required to file or bill secondary insurance but may do so as a courtesy.

**Billing**

Balances which are 30 days old or older will incur a monthly 1.5% finance charge with equals an 18% per annum rate. There is also a $30 returned check fee.

**Collections**

Any account that has not received payment in 90 days is subject to be turned over to a collection agency that will pursue the responsible party for reimbursement. This may negatively impact your credit history and may limit the treatment you can receive at our office.

# Our Office Appointment Policy

At Garners Ferry Dentistry appointments are made in advance by reserving one-on-one time, often for one or more hours, for you with our Doctor and/or Hygienist. We spend a significant amount of time meticulously preparing for your appointment by sterilizing, organizing and arranging a setup of items prior to your arrival. This ensures that we are ready to deliver a high standard of care and treatment that you expect from us right when you walk in the door.

Because of this preparation time, our office has created the following agreement to ensure a mutual understanding regarding the importance of the appointment scheduling process. To reserve your appointment with our office, we may require that you leave a credit card number on file with us – similar to what is required to sometime reserve a hotel room. This process allows you to reserve a treatment room and the care of our staff. We require that you give notice of two (2) business days prior to the time of your appointment for cancelling or rescheduling. We understand that emergencies happen but any change to this policy is per the sole discretion of Garners Ferry Dentistry.

Below are charges for failed appointments, no-show appointments or canceling and / or rescheduling appointment without a two (2) business day notice.

- New Patient Appointment (Adult): $50.00; New Patient Appointment (Child): $25.00
- Treatment Appointment (<2hours): $75.00; Treatment Appointment (2+ hours): $150.00
- Checkup Appointment (Adult/Child): $50.00;
- All Other Appointments: $50.00 / Hour

We also have the right to cancel any appointment not confirmed beforehand. By signing below, you indicate that you understand and agree to this policy, and that you authorize us to charge your credit card in the event you miss an appointment, as outlined in the policy above.

Printed Name: _____

Credit Card Number: _____ Exp: _____ CVS#: _____

Patient Signature: _____ Date: _____