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**Harris -Obermiller DDS.**

**Financial Policy**

**Relationship to patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for choosing us as your dental health care provider. The following is our Financial Policy. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the Dentist/Hygienist.

* Your insurance policy is a contract between you and your insurance company. **We must emphasize that as your dental care providers, our relationship is with YOU, not your insurance company**.
* All charges are your responsibility from the date services are rendered whether your insurance company pays or not. Not all services are a covered benefit in all contracts; please refer to your personal benefit package.
* Co-payments are due at the time of service. **Your estimated portion of what your insurance does not cover is due at the time the service is rendered.**
* When we do not participate with a certain insurance plan, your out-of-pocket expenses may increase.
* If your insurance company does not pay their portion within 45 days, we ask that you contact the carrier to help speed up the process***.* If there is a remaining balance due after payment has been received from your insurance company, we expect you to pay that balance within 30 days**. If this is not possible, we encourage you to contact us so we may assist you in the management of your account.
* If you would like to know an estimate of your insurance’s coverage, we can submit a pre-authorization to your insurance. This will give an estimate of your out-of-pocket expenses. These usually take 3-4 weeks to process and be returned to us.
* Your insurance company will only pay for services that are covered in your personal policy: where applicable and determined as reasonable and necessary. Your policy may deny payment for any services.
* Gentle Dental cannot legally waive the payment of deductibles and/or co-payments.

***Payment is due at the time services are rendered. If my insurance denies payment, or only pays a portion of the charges, I agree to be personally and fully responsible for payment in full.***

We offer a 5% discount when payment is made in full by cash or check.

If I do not pay the entire new balance within 60 days of the monthly balance date, a late fee of 1.5% on the balance then unpaid and owed will be assessed each month.

**Please mark how you would typically pay for out-of-pocket payments:**

\_\_\_\_ Cash \_\_\_\_ Check \_\_\_\_ Debit/Credit Card \_\_\_\_Care Credit (Interest free financing upon approval)

*Our office implements a $75.00 Failed Appointment Fee which is incurred after the second failed appointment. This fee mush be paid before any future appointments are made for any family members.*

**Signature of Patient/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_