



Dr. Gloria Dental Care

CREATING BEAUTIFUL & HEALTHY SMILES

FINANCIAL POLICY / BASIC INSURANCE INFORMATION

We feel that everyone benefits when there is a definite and clear understanding of our financial policy prior to treatment.

1. ALL PATIENTS, WHO DO NOT HAVE DENTAL INSURANCE, ARE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE. MONTHLY PAYMENTS CAN BE ARRANGED, IF QUALIFIED. PLEASE ASK OUR OFFICE MANAGER FOR ADDITIONAL INFORMATION.
2. An estimate of your total fee for treatment will be outlined in detail with you at the time of your consultation.
3. **PATIENTS WITH INSURANCE:** Our office will gladly file your insurance if you provide us with the proper information. The estimated amount not covered by your insurance is due at the time of treatment. Once we received payment from your insurance company, all necessary adjustment will be made. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance. If your insurance company does not respond within 60-days, you are responsible for the remaining balance.
4. We ask that you leave us a copy of your credit card to be placed on file. In case where there is a balance on your account for more than 60-days and has not been resolved, we reserve the rights and authorized by you to charge the balance onto your credit card.
5. **PLEASE NOTE:** There will be a broken appointment charge for any patients who cancel with less than 24-hour notice or who are not present at the appointment time. The charge will be \$50 or 15%, whichever is greater, of the total fee for the treatment. If the patient has three broken appointments, we cannot schedule any more appointments with the patient.
6. Delinquent accounts will be handed over to collection agencies, small claims court or to an attorney. Patients will be responsible for ALL fees associated with collections.

IT IS YOUR RESPONSIBILITY TO MONITOR YOUR BENEFITS AND ANNUAL MAXIMUM. We will be happy to assist you with any resubmissions, handling insurance queries, processing follow-ups, and lost claims. If your dental benefits plan requires a 'pre-determination' or 'prior authorization,' we will submit a treatment plan for review by the third party. However, please remember that the financial obligation for dental treatment is between you and this office. The third party payer is responsible to you and not to this office.

Payment Options:

1. **CASH** – includes money orders and personal checks. (There is a \$25 fee on all returned checks)
2. **VISA / MASTERCARD / AMERICAN EXPRESS / DISCOVER** – We accept credit card payment for treatment to the extent your credit limit permits.
3. **CARE CREDIT** offers a separate line of credit to cover your entire family's health care needs.

I have read and agree to the foregoing. I have had the opportunity to ask financial-related questions. My signature below constitutes my agreement and understanding.

Patient / Guardian's Signature

Date: _____