Greashaber Dentistry

Financial Statement and Cancellation Policy

Financial Statement

We are committed to providing you with the best possible dental care. We also want to serve you in a manner which is as comfortable and pleasant as possible. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will discuss your proposed treatment and give you any co-pay estimates, and answer any questions that we can about your insurance. In order to do this, we need your employer or group information, member ID (which may be your SSN#), legal name, and birth date. If you have dual insurance, we require the member ID (which maybe your SSN#) and the employer or group information on the first day services are rendered.

Patients without insurance are responsible for the balance in full on the day of service, unless other arrangements have been made.

The extent of your insurance benefits is defined in a contract between you, your employer and the insurance company. We are not a party to that contract, and therefore are not responsible for any of the decision-making with regards to the policy. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claim form and sending it in promptly. All co-pays are due at the time of service. We will work with your insurance company to receive payment, if after six months we are unable to collect, the balance will be due and you may receive reimbursement from the insurance company.

ANY AND ALL CHARGES FOR SERVICES ARE ULTIMATELY THE RESPONSIBILITY OF THE PATIENT. WE WILL DO OUR BEST TO ESTIMATE INSURANCE COVERAGE AND INSURE TIMELY FILING OF CLAIMS, BUT ANY UNPAID BALANCE IS THE PATIENT'S RESPONSIBILITY.

I authorize the release of dental information necessary to process an insurance claim. I authorize payment of dental benefits to the provider for professional services rendered. I understand that when my dental insurance coverage excludes or does not fully cover services rendered that I am responsible for the account balance.

_____ Date:_____

Signature

Cancellation Policy

We understand that things come up that are out of your control. However, we require 24 hours notice to cancel an appointment and avoid a cancellation fee. If more than two appointments are missed or canceled with less than 24 hours notice, you may be dismissed from the practice. **Any appointments missed or cancelled less than 24 hours in advance will be subject to a $50 fee.**

_____ Date:_____

Signature