First:_____

FINANCIAL/PAYMENT POLICY Last:_____

Thank you for choosing **Gentle Touch Family Dentistry** as your primary dental care provider. We are committed to providing you with quality dental care. Below are the payment policies for our office. Please read, initial and sign in the spaces provided. If you have any questions please feel free to ask. A copy can be provided upon request.

1.INSURANCE

We participate with most insurance plans. If you are insured by a plan we do not participate with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

_____ INITIAL

2.CO-PAYMENTS AND DEDUCTIBLES

All co-pays and deductibles must be paid at the time of service. Your co-payment is only an estimate. Occasionally, insurance companies do not pay all that is expected. When this occurs, the remaining balance is the patient's responsibility. This arrangement is part of your contract with your insurance company. Treatment requiring laboratory appointments;(i.e.) Crowns, Partials or Dentures require a commitment payment of 1/2 down prior to the beginning of treatment.

_____ INITIAL

3.NON-COVERED SERVICES

Please be aware that your insurance company may not cover some of the necessary services rendered. You will be responsible for these services in full on the day of treatment.

_____ INITIAL

4.CLAIM SUBMISSION

Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit your claims for payment directly to us for services rendered. It is your responsibility to comply with any request for information that the insurance might need in order to pay the claim. Failure to do so will result in a transfer of the balance to you.

_____ INITIAL

5.NONPAYMENT

If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay the balance in full. Partial payments will not be accepted unless negotiated. Please be aware that if a balance remains unpaid, your account will be referred to a collection agency.

_____ INITIAL

6.COVERAGE CHANGES

If your insurance coverage changes, please notify us before your next appointment so that we can make the appropriate changes to help you maximize your benefits.

_____ INITIAL

7 .MISSED APPOINTMENTS

Our time is valuable, just as yours. As a courtesy to other patients who may need help during your scheduled appointment time there is $50.00 fee for appointments canceled without a 24-hour notice. Extended Appointments will require a $200 down payment when the appointment is made, that fee will be used for the appointment time if it is cancelled without a 24 hour business day notice.

_____ INITIAL

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I acknowledge that I have read and accept the financial/payment policy of **Gentle Touch Family Dentistry** and that all of my questions have been answered to my satisfaction.

X_____ _____

Patient or Guardian Signature **Date**