Patient Financial Policy

Our office strives to provide the highest quality dental care at affordable prices. Our patients receive prompt attention and excellent service. A satisfied patient returns for additional services, refers others to the practice and pays their bill promptly. To help maintain a good relationship with our patients, this office has adopted a written financial policy. The purpose of this policy is to eliminate confusion and misunderstanding regarding the financial arrangements offered by our office. Our office communicates this policy to each patient.

For those with insurance benefits, we are happy to bill your insurance AS A COURTESY TO YOU. Please note that ***your insurance contract exists solely between you and your insurance carrier***. **WE WILL FILE YOUR INSURANCE CLAIM, BUT WE CANNOT GUARANTEE ANY BENEFITS.** Your insurance plan is a benefit to you that helps with dental therapies. These benefits assist with treatment but may not cover all services necessary to restore your dental health. Any questions or comments regarding your benefits should be directed to your insurance carrier.

_____ Per our office policy, we will be collecting estimated patient co-pays for all basic and major services (multiple fillings, crowns, partials, bridges, etc…) the day the services are rendered. **We are contracted with Care Credit, and Lending Club to provide our patients with 0% interest payment options. See your treatment coordinator for details including monthly payment estimation for your treatment plan**.

_____ Dr. Gearin and hygienist block out their schedule specifically for you when appointments are made. If you are unable to keep your appointment and need to reschedule ***less than 48 hours before your scheduled time, there will be a $50 cancellation fee per hour booked.***

_____ Delinquent accounts will be sent to a collection agency. I understand that if my account becomes 90 days delinquent and is sent to a collections agency, I will be responsible for all collection agency fees as well as court costs and attorney fees associated with the collections of this account.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account and for any services rendered. I have read and understand the information provided within this policy and I will notify you of any changes in my insurance if applicable.

Signature: _____Date: _____