JEFFREY J. DENT, D.D.S.

Practice Limited to Periodontics

**ALL PATIENTS MUST COMPLETE OUR “PATIENT INFORMATION FORM” BEFORE SEEING DR. DENT**

We are committed to providing you with the BEST possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our FINANCIAL POLICY is important in our relationship with you. We will be happy to answer any questions to the best of our ability concerning fees and insurance.

**PAYMENT IS DUE A THE TIME SERVICE IS PROVIDED. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMEX, AND CARE CREDIT. RETURNED CHECKS WILL BE SUBJECT TO ADDITIONAL FEES.**

**REGARDING INSURANCE:**

If you have insurance, we will file your insurance and help you receive your maximum benefits. If your insurance company has not paid the FULL BALANCE within 45 days, you are responsible for the account balance. If they pay more than the balance due, we will issue a refund check to you immediately. You are responsible for the timely payment of your account regardless of insurance status.

Insurance is a contract between you and your insurance company. We are not a party to THAT contract. If we are a participating provider with your group plan, we will handle your claims according to the agreement with the insurance company, if one exists.

We file insurance as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, non-covered services, “usual & customary” charges, etc., other than to supply factual information as necessary regarding treatment. Additionally, we will file secondary insurance for you after the primary responds, but it is our policy to use the primary insurance estimates when calculating your portion. In some cases, secondary insurance considers what the primary pays to be proper compensation and benefits are not coordinated by them for payment.

**MISSED APPOINTMENTS:**

**Unless cancelled at least 24 hours in advance, our policy is to charge for broken/missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.**

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

* **RESPONSIBLE PARTY SIGNATURE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* **NOTE: IF DENTAL INSURANCE IS IN ANOTHER PERSON’S NAME, PLEASE GIVE INFORMATION.**

**Name of Person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Place of Employment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_