GRUNWALD

FAMILY DENTISTRY

Financial Policy:

Thank you for choosing Grunwald Family Dentistry as your dental provider. Although billing is not always a comfortable topic, we want to keep you aware of our current office financial policies. We ask that you please read, initial, and sign this policy before any treatment.

Payment for dental care is different for everyone because there are many insurance companies and different types of coverage. Since you are the person seeking care, please know that you are responsible for the payment of the bills related to your care. To help you, we will bill your insurance carrier(s) for you, when you have given us a copy of your current insurance information.

Financial Terms:

Payment types accepted- Cash, personal check, VISA, Mastercard, Discover, American Express, and Care Credit.

Co-Payment- The fixed dollar amount **set by your insurance plan** that **MUST** be paid by you at the time of your visit. The co-pay **cannot** be "waived" by our practice, because it is a rule from your insurance carrier.

Deductible- The annual dollar amount **set by your insurance plan** that is deducted from insurance benefits and **MUST** be paid by you. The deductible **cannot** be "waived" by our practice, because it is a rule from your insurance carrier.

Self-Pay- The dollar amount to be paid by patients who have no insurance benefits. This fee is due at the time of the visit.

_____Initials

Insurance Coverage and Payments:

You, the patient, are responsible for annual deductibles, co-payments, and **ANY** services that are not covered at the time services are rendered. If you don't know what your insurance coverage is, please contact your insurance company. It is up to you, the patient, to know your own insurance plan and the benefits provided. As a courtesy, we are happy to help you in understanding your benefits to the best of our ability. However, your benefit plan is between you and your insurance carrier, **NOT** between our office and your insurance carrier.

_____Initials

"No Show" for Appointments and Procedures:

We understand that emergencies happen for our patients, just as they do for us. However, when a patient cancels an appointment without enough notice, or doesn't show up, we can't use that time to service our other patients. We ask that you please call at least 24 business hours in advance to cancel or reschedule appointments. Patients who do not, **may be charged a $25.00** fee. **This fee will be charged to the patient, not to your insurance carrier.**

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Returned Checks/ Rejected ACH Withdrawals:

A $35.00 fee will be added to your account for any checks returned or ACH withdrawals rejected by your financial institution. This is in addition to any fees your financial institution may charge you.

_____Initials

Authorization to Release Information/ Pay Benefits:

I authorize Grunwald Family Dentistry to release information contained in my dental record, to any third party payer, insurance agencies, or carriers which are responsible in whole, or in part for services rendered.

I assign and authorize direct payment of all dental benefits and other forms of payment which relate to the care provided to me by Grunwald Family Dentistry for application to my bill. I assume FULL FINANCIAL RESPONSIBILITY FOR PAYMENT of all expenses associated with my care and treatment, including any portion of charges that are not covered/paid for by my insurance carrier.

I, the undersigned, have read, clearly understand, and agree to the provisions of this financial policy. I also understand and agree that the terms of the financial policy may be amended by the practice at any time without prior notification to the patient.

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Signature of the patient or Guardian

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Printed name of the patient

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Date