OFFICE FINANCIAL POLICY

PATIENTS WITHOUT DENTAL INSURANCE

Please initial the billing option of your choice:

_____ I am responsible for all fees related to my dental care treatment, and that full payment for all dental treatment is to be made at the time treatment is performed.

PATIENTS WITH DENTAL INSURANCE

Please initial the billing option of your choice:

_____ Pay my total balance now and seek reimbursement directly from my insurance company.

_____ Pay only my ***estimated*** portion (DEDUCTIBLE AND/OR COPAYMENT) now and have the balance billed to my insurance provider. If my insurance fails to pay, the balance remains my responsibility and I must pay all amounts due.

I will be given the opportunity to have a pre-authorization estimate of fees from my insurance company, prior to being treated All fees are ***estimated* as accurately as possible. I understand that if my insurance has not processed my claim within ***120 days*** after the service(s) are rendered, I will be responsible for the remaining balance. I am aware that even a ***preauthorization estimate is not a guarantee for payment*** (from my insurance company) and I may be required to pay the entire treatment cost.**

BROKEN OR MISSED APPOINTMENTS

- I understand there is a **$50** fee for same day cancellations and all broken appointments.

OFFICE POLICIES

- We reserve the right to charge a fee for any appointments not kept by the patient. After two broken or missed appointments, the dentist may discontinue treatment.
- ***Unpaid accounts may be turned over to a collection agency.***
- There will be a **$50** service charge on any returned checks.

I have read, understand and agree to the above office Financial Policy.

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Signature of Patient, Parent or Guardian **Date**

DR. GWENDOLYN DANIELS-PARKS & ASSOCIATES