

James W. Gordon, D.D.S.
Financial Policy

Thank you for choosing us as your dental provider! We are committed to your treatment being successful. Payment for your services is part of your treatment. We understand that the financial aspects of healthcare can be difficult to understand and confusing. Our office will try to do everything we can to help you.

The following is a statement of our Financial Policy, which we require you to read, sign, and date. This agreement will remain in effect for all services rendered during your time at our practice.

We accept cash, debit cards, checks, AMEX, Visa, MasterCard, and Discover.

Insurance

We will file claims with your insurance company at no charge as a courtesy. We research your benefits to the best of our ability to be able to provide you with an **estimate** of what your insurance will pay. We require your out-of-pocket portion to be paid in full at time of service unless arrangements have been made prior to treatment. If we are unable to collect your benefits after 90 days, unless there is an error, the total balance will be your sole responsibility.

Your insurance policy is a contract between you and your carrier. **You** are responsible for payment of all services *regardless* of what the insurance company pays. Some of our services may not be a part of your benefit plan, or not considered usual and customary by your insurance company. These services are being planned for your dental well-being, **NOT** your insurance company's bottom line. You will be responsible for payment of any difference. **We will be more than happy to submit a preauthorization to your insurance company for your treatment before services are provided at your request.** We will NOT be responsible for differences between our estimates and payment from your insurance company for services. If you are concerned, PLEASE request that we submit a preauthorization!

Self-Pay Balances

If you do not have insurance coverage or if non-covered services are provided, payment will be due in full at time of service unless arrangements have been made prior to treatment.

Missed or Late Cancellations

We understand there may be times you are unable to keep your appointment. If you need to cancel an appointment, we require you to do so at least 24 hours prior. There may be a missed appointment charge of \$25.00 if this occurs more than 3 times. If you are more than 15 minutes late, you may be asked to reschedule your appointment.

I understand in signing this statement that I am financially responsible to James W. Gordon, D.D.S. for all fees incurred on my behalf and/or on any dependents, and all costs of collection, including but not limited to service, collection agency, and attorney charges, if necessary. I hereby authorize the insured's insurance company to pay directly to James W. Gordon, D.D.S. any and all of the benefits otherwise payable to me. I further authorize the release of health care information for the purpose of evaluating and administering claims for benefits.

Patient Signature or Parent/Legal Guardian if Patient is a Minor

Date