OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are fully committed to the successful conclusion of your prescribed dental treatment. Please understand that payment for services rendered is considered an integral part of your treatment. The following is a statement of our Financial Policy which should be read carefully by you and signed prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER CARDS

WE OFFER AN EXTENDED CREDIT PLAN WITH PRIOR CREDIT APPROVAL (for some procedures)

Regarding Insurance:

We will verify your insurance coverage upon your arrival in our office. If we are unable to obtain verification of benefits while you are with us, you may be required to pay in full for that visit. It should be recognized that any balance is your responsibility whether your insurance company pays or not. **Your insurance policy is a contract between you and your insurance company;** we are not a party to that contract. In the event we do accept assignment of benefits, we require that you provide a credit card with authorization to bill that account for the balance. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for all our patients and we charge what is usual and customary for this community. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Missed Appointments:

Unless canceled, at least 24 hours in advance, our policy is to charge a fee of $50.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have fully read, understand and hereby agree to this financial policy.

X_____ Date_____

Signature

AUTHORIZATION FOR US TO RELEASE MEDICAL INFORMATION

I hereby authorize Dr. Gilleland to release any medical/dental information regarding myself or my child to my physician, insurance company, lawyer, or anyone else specifically named by me. This information includes records, and/or referring physicians reports or copies thereof.

I have read this statement carefully. I understand it completely and sign without any reservations, not even the slightest doubt.

SIGNATURE_____ DATE_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician, hospital, clinic or other medical facility, or any other persons having any records or knowledge of me or my health, or that of my child, to give Dr. Gilleland any and all information regarding the undersigned or my child, or copies thereof, which may be pertinent to my owner or my child's dental care.

SIGNATURE_____ DATE_____