Please read and initial:

\_\_\_\_\_\_Financial Policy: It is the goal of our practice to provide you with the finest oral care and financial services. Patients will be scheduled for treatment after financial arrangements are made. Our financial associates are available to answer any questions you have.

\_\_\_\_\_\_Insurance policy:Patients are expected topay their portion of insurance agreement including the co-pay and deductibles. As a courtesy to all of our patients with insurance, we will file dental services with primary insurance company, and if applicable with secondary insurance. The normal time allowed for insurance response is 30 days. Any charges remaining on patient account after the insurance coverage are ultimately patient’s responsibility.

\_\_\_\_\_\_Payment Policy: Our office requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the financial department. When other arrangements are made, patient authorizes Galleria Dental Arts to make such inquires with any credit bureau regarding financial responsibilities that are deemed necessary.

\_\_\_\_\_\_Our practice requires a 24-hour notice if you are not able to make your appointment. Without your notice, a cancelation fee of $50.00, will be charged to your account.

Patient Authorizations:

\_\_\_\_\_I authorize Galleria Dental Arts to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any required information to outside health practitioners and for the purpose of processing insurance claims.

\_\_\_\_\_I understand that my insurance policy is a contract between me and my insurance company (ies) and that I am responsible for all fees. Collection Fees will be applied for all delinquent accounts.

\_\_\_\_\_I authorize and request my insurance company (if applicable) to pay dental benefits directly to Galleria Dental Arts otherwise payable to me. I understand that my dental insurance career may pay less than the actual billed services and that I am responsible for the remaining balance.

\_\_\_\_\_I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Power of Attorney \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_