Financial Policy
Jacob Grapevine, DDS

Patient Name: _____**Date**:_____

Basic Policy: Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks, and most credit cards. We also offer third party financing and no interest terms with Care Credit and Citi financing. There is a $25.00 returned check fee due and payable from you for each check payment returned to us by your bank.

Patients with Insurance: As a service we accept "Assignment of Benefits" and will bill your insurance carrier, provided paperwork and all insurance information is provided to us. We also assist you in billing secondary insurance carriers, if applicable, and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles, which are due at time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 45 days of billing, any unpaid professional fees are due and payable in full from you.

Non-Covered Charges: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim.

Cancellation of Appointments: Our goal is to provide high quality care to our patients and respect their schedule as well. In fairness to other patients, and the office staff, we require at least a 48 hour notice when cancelling and appointment. Any patient who is more than 15 minutes late may be considered a "no show" for their appointment.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to my family and me..

Patient's Signature: _____Date: _____

Insurance Information Needed To File Your Claim

Insurance company: Insured SS#:

Address: Insured Date of Birth:

Plan # or Group #: Supervisor Phone#:

Employer Name:

Address:

Assignment of Benefits Authorization
I authorize payment of dental benefits to the named provider for professional services rendered.

Signed:

Date:

Release of Information
I authorize the release of any dental information necessary to process this claim

Signed:

Date: