# Financial Policy
# Jacob Grapevine, DDS

**Patient Name**:_____**Date**:_____

**Basic Policy**: Payment for services rendered is due in full at 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. 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 Dental Insurance**: As a service we electronically file claims to your dental insurance company. You must provide proper insurance information and paperwork required. We are not responsible for missing insurance information or incorrect insurance information that may delay or decline your insurance claim. We do not assist in filing secondary insurance claims or medical claims. Every effort will be made to closely estimate your co-payments, deductibles and expected insurance coverage. Payment is due in full at time of service and assignment of benefits will be sent to you. You have the contract with the dental insurance provider. If the insurance company has not paid within 45 days of billing, we recommend you contact your insurance carrier.

**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 an appointment. If less than 48 hours or a no showing to the appointment, we reserve the right to refuse scheduling a new appointment. We may contact you when something is available or you may pre-pay for a future planned 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 me and/or my family.

**Patient Signature**:_____**Date:**_____

<u>Insurance Information Needed to File Your Claim</u>

Insurance Company: Insured SS#:

Address: Insured Date of Birth:

Plan# or Group#: Supervisor Phone#:

Employer Name:

Address:

Release of Information
I authorize the release of any dental information necessary to process claims.
Signed:_____
Date:_____