Gentle Breeze Family Dentistry

Financial and Appointment Policy

1. Payment is expected at time of service.
2. Dr. Orr offers an **in house financing option** through her and financing options from other finance companies.
3. For our patients without insurance we offer a **Dental Savings Plan** to help cover the cost of some dental treatment and procedures.
4. Please note that all accounts over 60 days ***could*** be assessed an 18% per annum interest charge.
5. If you are unable to keep your appointment please call us at least **24 hours** in advance or a **$50.00** cancellation fee ***could*** be applied to your account.
6. **If you are more than 15 minutes late for your appointment** it will be assessed at that time if the appointment goals can be achieved. In an effort not to make the patient after you wait, we may have to modify your appointment goals or reschedule. We appreciate your understanding and cooperation.

I have read and understand the above financial and appointment policy for the office of Gentle Breeze Family Dentistry.

Signed:_____ Date:_____

Insurance Co-payments and Responsibility

Estimated insurance benefits will be discussed during the financial agreement portion of your visit. Our office will file your insurance claims to help you receive the benefits that you are paying premiums for. Dental benefit plans vary and will only pay what your insurance company allows for each service, regardless of what the actual fee might be.

1. Deductibles and co-payments are due at time of service.
2. If any of your insurance information has changed report changes immediately.
3. Understand that your plan is a contract between you and your employer and the insurance company. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
4. Please pay any account balance not paid by insurance in a timely manner.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all cost of dental treatment. I grant the right to the dentist to release by dental/medical histories and other information about my dental treatment to third party payers.

Signed: (Patient or Insured Party)_____Date_____