FINANCIAL POLICY

Welcome to Dr. Gillham's office. We are committed to providing you with the best possible care. Helping you with the financial aspect of treatment is one way we can make your initial visit with us more comfortable.

If you have dental insurance, please refer below for further information. If dental insurance is not available, payment in full is expected at the time of each appointment. Cash, check, Visa, Discover and MasterCard are accepted. A 5% reduction is given when full payment is made by cash or check. Someone in our business office can answer any other questions regarding fees, our financial policy, or your responsibilities.

IMPORTANT INFORMATION REGARDING DENTAL INSURANCE

Your complete insurance information must be presented at the time services are provided and then updated as necessary.

We file insurance as a courtesy to our patients. It is impossible for us to have complete knowledge about the numerous dental insurance companies and programs. Therefore, we cannot be responsible for keeping up with the ever changing policies of each individual insurance plan. For complete information regarding your benefits, please contact your insurance company directly or refer to the benefit booklet your employer or insurance company may have provided you. This information will help you make informed dental care decisions at each appointment.

We also encourage you to become familiar with your policy exclusions, limitations and maximums. The frequency of payment for some procedures may be limited by your insurance company. This is most often encountered in a pediatric dental office with fluoride treatments, exams, cleanings and x-rays.

We allow 60 days for your insurance company to make a payment. After this time, all inquires and follow-up on payments become your responsibility.

For any treatment appointments (appointments other than routine check-ups), we will *estimate* your benefits based on limited information received from your insurance company. Your *estimated* payment (the estimated amount your insurance will not pay), will be required at the time of each treatment appointment.

Thank you for your cooperation with your dental insurance coverage. Please have your insurance card ready for us to copy.

I have read and understand the above information. I also understand I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay. This signature will also serve as signature on file for assignment of insurance benefits.

_____ _____

Signature **Date**

SUBMIT