Our Financial Policy

Thank you for choosing Greg J. Herd a Dental Corp as your dental provider. The following is a statement of our financial policy, so we ask you to read and sign this policy prior to any treatment.

PATIENT PORTIONS ARE DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER/AMEX/CARECREDIT

Indemnity Insurance (Initial _____)
We do require your deductible and/or percentage of treatment to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company; we are not a party to the contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and customary under your dental insurance.

Usual and Customary Rates (Initial _____)
Our practice is committed to providing the best treatment for our patients and our fees are usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

PPO Insurance (Initial _____)
Regarding your PPO contract. By law, as your provider, we are required to collect your deductible and/or percentage due at each and every visit; therefore, in accordance of your contract, you will be required to pay those amounts.

Patients with NO INSURANCE (Initial _____)
Patients without any insurance coverage are responsible for payment in full at time of service. A courtesy discount may be applied to your account if your balance is paid with CASH at the time of service. There is no discount applied for check or credit card payments.

Minor Patients (Initial _____)
The adult accompanying a minor (whether a parent or guardian of the child) is responsible for the patient portion at time of service. Unaccompanied minors must have *prior* financial arrangements made and a medical release form in their chart.

Missed Appointments (Initial _____)
Our policy is to charge for missed or cancelled appointments at the rate of a normal office visit ($75) unless we are notified of any appointment changes 2 working days in advance. It is our office policy to dismiss patients from our practice after missing 2 appointments without following the proper cancellation protocol. Please help us serve you better by keeping scheduled appointments.

- We make every effort to contact you in the event there is an outstanding balance on your account; however, if we cannot reach you (i.e. you've moved and forgot to notify us), would you please provide us with the name, phone number and address of a person who would be able to contact you for us.

Name _____ Relationship to patient _____
Phone Number _____

Thank you for understanding our financial policy. Please let us know if you have any question or concerns.
I have read the financial policy. I understand and agree to this financial policy.

X_____ **Date** _____
Signature of patient or responsible party