Gentle DENTISTRY
Gentle Family & Cosmetic Care
4135 Alexandria Pike #209
Cold Spring, KY 41076
859-441-0600

FINANCIAL POLICY

THANK YOU FOR CHOOSING DR. SMITH AS YOUR PROVIDER. WE ARE COMMITED FIRST AND FOREMOST TO PROVIDING THE BEST AVAILABLE TREATMENT.

PAYMENT

Payment is expected in full at the time treatment is rendered. Our office accepts cash, check, Visa, Mastercard and American Express. We do offer payment plans 6 months interest free or 60 months with interest through Care Credit(upon credit approval). If you have dental insurance, it is required you assign payment from the insurance company to Dr. Smith, unless you pay in full for your treatment. All procedures and subsequent costs not covered by your dental insurance plan including deductibles, co-pays, age and/or frequency limitations, or non-covered services will be expected at the time treatment is rendered. Dr. Smith is not responsible for any non-covered services.

REGARDING INSURANCE

We encourage you to review your dental benefits and coverage. In good faith we contact your insurance carrier for your dental benefits so we can estimate expected payment for services provided. Your insurance policy is a contract between you and your employer or group, Dr. Smith is not part of that contract. We will give you an **ESTIMATED CO-PAY AMOUNT DUE** for treatment however we cannot guarantee the estimate as we can only provide you the information given to us by you and/or the insurance company. We will submit claims to your insurance carrier for services provided. Insurance companies are required by law to process claims within 30 days of date claims are submitted. If payment is not received from your insurance carrier within 45 days you will be billed for the account balance in full. If your plan changes, please notify our offices immediately.

MISSED APPOINTMENT POLICY

Unless cancelled at least 24 hours in advance, we have the right to charge $25 for missed appointments. We ask that you respectfully give consideration when you commit to scheduling an appointment keeping in mind we will hold that appointment specifically for you. If you miss an appointment you not only do a disservice to yourself, you forfeited a time another patient that needs care could have come in for.

DELINQUENT ACCOUNTS

I have read the above financial policy. I understand I am ultimately responsible for all charges for treatment regardless of coverage by my insurance carrier. I assign benefits from my insurance carrier to be payable to Dr. Smith.

I have completed and reviewed all the information given. All statement are true to the best of my knowledge. If there is a change in my information I understand it is my responsibility to inform Dr. Smith. I consent to all necessary dental treatment being performed by Dr. Smith. In the event that the account would be turned over to collection agency or attorney, due to non-payment on the account, I am also responsible for all attorney, collection fees, and charges.

_____ _____

PRINTED PATIENT/GUARANTOR NAME DATE

_____ _____

SIGNATURE DATE