GANE & KARSHNER FAMILY DENTISTRY

Our Financial and Appointment Policies

Thank you for choosing **Gane & Karshner Family Dentistry** for your dental care, where we are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial & Appointment Policies. Please read, initial and sign that you understand each of our office's expectations of you.

____**Co-Payments:** All applicable deductibles, co-insurance amounts and non-covered service fees are due at the time service is rendered. For your convenience our office accepts cash, personal checks, Master Card, Visa, American Express, Discover & Care Credit.

____**Payment Plans:** We do not offer in-house financing; however, we have partnered with Care Credit which offers several short term, interest free payment plans and long term payment plans with minimal interest. You can apply for Care Credit in our office with the assistance of a staff member, over the phone at 1-800-365-8295 or online at www.CareCredit.com.

____**Dental Insurance:** As a courtesy, we file any dental insurance claim as long as you provide us with the correct insurance information, a copy of the card & the insured's social security number & date of birth. Our office will call your insurance company prior to any treatment to verify dental benefit coverage. The benefits you receive are based on the contract between you and/or your employer and the dental insurance company, not our office. Some services you may need or want may not be covered by your benefit plan.

____**Medicaid Insurance:** Patients with Medicaid Dental Coverage must provide a copy of their Medicaid card and photo ID along with their $3.00 co-pay (if over 21) in order for our office to submit claims on their behalf.

____**Unpaid Insurance Balances:** Every effort is made to process your dental claim efficiently and quickly as well as to calculate your patient co-insurance amounts for each date of services. However, they are still on estimates based on the current information you and your dental benefit plan provided to our office. The exact amounts are not known until the claim has been paid. You are responsible and will be required to pay for any remaining account balance after your insurance has paid their portion.

____**Appointment Cancellations:** We make every effort to accommodate you when scheduling an appointment. Thus, we trust that no change in your appointment will be necessary. However, if this becomes necessary we require a 24 business hour notice to make changes in your reserved appointment time. We recognize that emergencies do occur, but abuse of our time and policies could result in dismissal from our practice. **WE DO NOT WANT THIS TO HAPPEN!!!**

____**Cancellation Fees:** We reserve the right to charge a $25.00 for any appointment missed or not cancelled within 24 business hours. As a result, this could also lead to dismissal from our practice. **WE DO NOT WANT THIS TO HAPPEN!!!**

We will be glad to discuss any questions you may have about our financial or appointment policies. We hope by presenting our policies we will avoid any misunderstanding and therefore have more time to dedicate to your dental care.

I hereby authorize all claims to be filed on my or my dependant's behalf, for the use of "my signature on file" for all insurance claims and for the benefits to be assigned to Gane & Karshner Family Dentistry. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my healthcare information for the purpose of obtaining payment for services rendered and determining benefits. This consent will remain in effect for as long as I or my dependents are a patient of record.

PATIENT NAME: _____ DATE: _____

PRINT PARENT/GUARDIAN NAME: _____

PATIENT/GUARDIAN SIGNATURE: _____