OFFICE POLICIES
Dr. L. Gary Painter

Effective 1/1/2014

CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

Initial_____

FILING INSURANCE

Our office files both primary and secondary insurance claims as a courtesy to you. Should your insurance company reimburse benefits to you, we ask that you pay for all services the same day they are provided to you. All estimated funds from a secondary insurance company will be due at the time of your first visit and will be reimbursed to you by your insurance company. Should you have more than two insurance companies, it will be your responsibility to file such claims. Should we file insurance as payment to our office and it is unpaid beyond ninety (90) days, you are then responsible for the balance in full and you will need to contact your insurance company to discuss reimbursement.

Initial _____

PAYMENT FOR SERVICES

All estimated patient portions are DUE AT THE TIME OF SERVICE. For your convenience we accept cash, check, Visa, Mastercard, Discover, and American Express. Should you require an extended payment plan, our office offers Care Credit for 3, 6, or 12 months interest free. (subject to credit approval)

Initial _____

ESTIMATING INSURANCE COVERAGE

We try our best, based on the information your insurance company provides us, to ESTIMATE out of pocket portion for services rendered. This, however, is only an ESTIMATE and is not a guarantee that your insurance company will cover the exact amount we estimate. Generally, insurance companies usually pay LESS than the amount we estimate. In such instances, you will be responsible for any remaining balance not paid by your insurance company. Should the amount be significant, various payment options are available to discuss. Should you desire to know the EXACT amount insurance will cover, a pre-treatment estimate can be filed on your behalf. Generally, it takes four to six weeks to receive a reply from your insurance company.

Initial _____

CREDIT CHECK

In the event that you would like us to extend you credit and allow payments to our office, we will run a brief check of your credit. This credit check is covered under HIPAA and will not show as an inquiry on your credit report.

Initial _____

PAST-DUE ACCOUNTS

In the event that your account balance extends beyond sixty (60) days, a 1-1/12% finance charge (18% APR) will be added to your account. Any balance unpaid beyond ninety (90) days will be considered delinquent and will be reported as such to the credit bureau and will be turned over to an attorney for collections. You will be responsible for any reasonable attorney fees, including all court costs, will be applied to your account in the event that we should require attorney's assistance in collecting the balance on your account. Any dispute arising under this agreement will be heard in the Circuit or Superior court of Allen County Indiana.

Initial _____

CANCELLATION NOTICE & MISSED APPOINTMENT FEE

We require a 2 day notice to cancel/reschedule any appointment. There will be a $50 fee for all cancelled/rescheduled/missed appointments without proper notice.

Initial_____

RETURNED CHECK FEE

There will be a $35 fee for all returned checks.

Initial _____

By signing below I understand and agree to comply with these policies.

_____ _____

Patient Signature Date