Family Dental Montgomery, Drs. Jerry & Eileen Gao, are committed to provide our Patients the optimum in dental care! Payment for dental services provided is part of that process. We want to ensure that you are informed of our Financial Policy and your Patient Rights & Responsibilities. Please review the statements below and initial beside that you have been informed of the specific items of our Financial Policy. Our Staff is available for any questions you may have and thank you for choosing our Office to care for your Family's Dental needs.

Patient Financial Rights & Responsibilities

________ Visa, Mastercard, American Express, CareCredit, Cash, and Check w/ proper ID are accepted payment
**Our banking institution will assess a $25.00 fee on any returned check s which will be added to your account.*

________ Payment is due at the time dental services are provided unless alternate payment arrangements have been confirmed with our Office 48 hours in advance of your appointment. This is applicable for estimated co-payments if the patient has Dental Insurance Coverage, and Patients without Dental Insurance Coverage.

________ An estimate of Dental Insurance Coverage (*if applicable)* obtained by our Staff does not guarantee payment of your dental claim. This information is an estimate only based on the information provided by your Insurance Carrier.

________ We will submit your Dental Insurance Forms (*if applicable)* and any required/requested information by your Dental Insurance Carrier to obtain your dental benefits.

________ Your Insurance Carrier (*if applicable)* has the final determination of the specific dental benefits and materials covered under your policy when the claim is processed. Patients share the responsibility to be informed of their specific dental benefits.

________ Any amount not paid by your Dental Insurance Carrier (*if applicable)* or any dental claim not resolved by your Dental Insurance carrier 45 days after the dental service was rendered will be the responsibility of the patient.

________ Balances over 60 days will acquire finance charge periodic rate of 1.25% not to exceed 15% APR.

________ Delinquent Accounts of any unpaid balances over 150 days will be reported to a Collection Agency. Additional charges to your account may occur and this will be added to the original unpaid balance.

Our Office adheres to the Patient Rights under **The Fair Credit Billing Act.** If you think you have been billed incorrectly, submit in writing to our office within 60 days of your first statement from our office in which the error or problem appeared. Please provide your name, account number, dollar amount of the suspected error, and describe the error, and if you can, explain why you believe there is an error. If you need more information, describe the item you are not sure about on your statement. You may call our office at 791-0030 to speak to our Staff but we will require written documentation of your concern if we are unable to resolve the matter via phone.
After we receive the written notice, we will acknowledge receipt of your written concern within 30 days unless we have already corrected the error.
Our Office will provide an explanation or correction of these charges within 90 days of receipt of your written concern. No attempt will be made to collect the amount you question or report you as delinquent during the investigation. We can continue to bill you this amount while we are investigating and you are responsible to pay any amount of your bill that is not in question. If there was no mistake on our part, you will be responsible for payment of the account, including any finance charges. If you fail to pay this amount we can report you as delinquent.

I agree to be responsible for all charges rendered for dental services and materials. If I have Dental Insurance Coverage, I assume all responsibility for charges and materials not paid by my policy.

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Signature of Patient/Responsible Party **Date**

A photocopy of this document may act as an original