PETER J. GAIDIS, D.M.D.
989 N. MAIN STREET
WILLIAMSTOWN, NJ 08094
(856)629-7806

FINANCIAL POLICY (Effective 10/10/2016)

Patient Name: _____ Date of Birth: _____
Dependents: _____ Date of Birth: _____
_____ Date of Birth: _____
_____ Date of Birth: _____
_____ Date of Birth: _____

****The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.**

PLEASE NOTE: PAYMENT IS DUE AT THE TIME SERVICE IS PROVIDED. We ask that you pay the deductible, copayment or any estimated amount not covered by the insurance company at the time of service. Our office accepts cash, MasterCard, Visa, Discover, American Express and Care Credit (a patient payment program offering a full range of No Interest and Extended Payment Plans). Personal checks will no longer be accepted unless you are sending in a payment by mail for a previously made payment arrangement or an additional balance not paid for by the insurance company. If a check is returned to our office from your financial institution, it will be subject to a $25.00 returned check fee. Any accounts with a balance of 90 days or older will be given to our collection agency. If the balance is not collected by our agency, it will be filed with small claims court. Any collection agency fees or court fees that we incur will be applied to the delinquent account and become the responsibility of the patient.

NON-INSURED PATIENTS: Patients who are age 65 and older and **do not** have insurance will receive a 10 % discount if the dental services are paid with a credit card or cash. No personal checks allowed.

INSURED PATIENTS:

• As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums. Please contact your insurance company for a detail of your benefits so that you are aware of your benefits and limitations. We will do all we can to ensure your estimate is as accurate as possible. The amount paid by the insurance company and the amount estimated by our office may differ due to many reasons specifically related to your plan. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. If you are unsure or would like to know the exact amount the insurance will pay, we can send a pre-determination to the insurance company on your behalf, however, this does not guarantee the insurance company will pay the claim.

• All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient,

not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract and does not have control of how or what the insurance will pay.

• We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. If we are providing treatment for your child/children, this form authorizes the release of any information concerning my (or my child's) healthcare advice and treatment provided for the purpose of processing claims for insurance benefits.

MINORS ACCOMPANIED BY THE PARENT/LEGAL GUARDIAN: The parent or legal guardian accompanying a minor, who has consented to treatment is responsible for full payment at time of service. This applies to minors with separated or divorced parents as well. We sympathize with your situation, but we cannot get involved in your personal financial situation.

UNACCOMPANIED MINORS: The parent or legal guardian is responsible for full payment at time of service. Consent for Treatment and/or payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

MISSED APPOINTMENT(S) AND CANCELLATIONS: In order to provide the best services to our patients, we require at least a 24-hour notice for cancellations or for rescheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A $50.00 charge will be assessed for any missed appointments (no shows)or last-minute cancellations. Multiple failed appointments may result in being dismissed from the dental practice.

CONSENT: I have read the Financial Policy of Dr. Peter Gaidis's office and understand/agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. By signing below, you are authorizing us to call you at any number provided including calls to mobile or similar devices for any lawful purpose. We may call by telephone regarding your/your dependants account(s) and/or appointment(s).

PATIENT NAME PRINTED:_____

PATIENT/PARENT/GUARDIAN SIGNATURE:_____

DATE:_____