Texas Grins Financial Policies and Agreement

To assist our patients, we offer the following information about our policies for fees, insurance, patient accounts, and payment. Please feel free to discuss these policies with our office manager.

FEES

Our fees reflect the value of service that you will receive in our office. When you receive treatment in our office, you agree to be financially responsible for the entire fee, independent of insurance coverage. If payment arrangements are needed, they must be made prior to treatment. Since we set a scheduled time for each patient, if an emergency arises, please give us a 24-hour notice. If an appointment is cancelled without proper notice, a fee will apply.

INSURANCE

Our office is happy to file insurance at no charge to our patients. We file all claims within 24 hours of your visit. We also verify your insurance coverage to advise you of your benefits. All claims are filed according to the guidelines set by the American Dental Association (ADA). In order to provide this service, the responsible party must sign an authorization for release of the information and assignment of benefits. Insurance coverage is limited to a portion of the fee agreed to by you and our office. All co-payments and deductibles are due at the time of service. We will be happy to estimate your benefits and your payment due prior to treatment. Please remember that insurance payments are only an estimate as most insurance companies pay on a schedule of "usual and customary fees". Usual and customary fees are fees that have been assigned to procedures by each individual insurance company. Although we feel that our fees are very comparable and reasonable, we are unable to determine the exact amount of insurance coverage as this varies from company to company. Any amount left following assignment of benefits will be billed to the responsible party. Once again, please feel free to ask our business staff if you have any questions. Accounts filed for insurance are due and payable by the responsible party 60 days after the billing date regardless of claims paid. ***Please note that we do not participate in most managed care dental plans. We feel that not participating in these plans allows us to provide the quality of care that our patients deserve.***

CONSENT

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents and other dental treatment embodies a certain risk.

I authorize payment of benefits directly to the provider as well as the release of all necessary information to my insurance carrier.

I have read this form and agree to the financial policies set forth by this office.

Patient Signature:______________________________ Date:__________________

*Parent or legal Guardian Signature if patient is a minor is required.