GEMINI
DENTAL TEAM

FINANCIAL AND INSURANCE POLICIES

Thank you for choosing our dental practice for your care. We are committed to your treatment and experience being successful and pleasant. We have made and will continue to make every effort to keep down the cost of your dental care. We request payment at the time of your dental treatment. We try to avoid sending statements, because the cost of paper work, postage and manpower affects our fees. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All balances are due upon services rendered.

RESERVING YOUR TREATMENT TIME

In order to reserve an appointment for services requiring more than one (1) hour, a 25% deposit of the cost of the treatment is required.

INSURANCE COMPANY VERIFICATION AND REJECTED CLAIMS

As a COURTESY to you, we will work with you and your Insurance Company to help you receive the maximum benefits available under your policy. We require patients with Insurance to pay their deductible plus any co-payments due on the day of their appointment. Certain dental work will require your payment prior to your appointment. Please remember NO insurance company will cover ALL dental costs. **Pre-Treatment Estimates** can be sent before treatment begins, if the patient chooses to, this process takes three to six weeks for a response. NOTE: Verification of insurance is NOT a guarantee of coverage: If the insurance company pays less than the **ESTIMATED** amount the patient is responsible for any remaining balance. If a claim for services is rejected by the insurance company due to plan exclusions, clauses, waiting periods, cancellation of coverage, or any other reasons, the balance will be the patient's responsibility. If after 60 days the Insurance Company has not paid, we will ask that you pay the balance of your account. Accounts over **60 days** will be assessed an interest of **15% APR**. We will help you seek settlement for a reasonable period of time. Be prepared to work with your Insurance Company yourself, if we are not able to gain settlement.

10449 NW. 41 ST. Doral, FL 33178 • Phone. 305-629-9909 • Fax. 305-629.9210 • geminidentaldoral.com

I ASSIGN MY PAYABLE DENTAL INSURANCE BENEFITS TO GEMINAL DENTAL.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE COST AND PAYMENT OF MY DENTAL TREATMENT WHETHER I HAVE INSURANCE OR NOT AND THAT I WILL PAY FOR MY CARE ACCORDING TO THE POLICIES OF THIS OFFICE.

BAD DEBIT / LEGAL ACTION

If an account is not paid in full or satisfactory arrangements are not made within the allowable time, the dental office reserves the right to refer the account to an attorney and/or a collection agency for collection of the balance. In the event the account is sent to collection, their fees will be added to the delinquent balance.

I, _____,
have read, understood and agree with the financial policies.

_____ _____

Patient Signature or Responsible Party Date

10449 NW. 41 ST. Doral, FL 33178 • Phone. 305-629-9909 • Fax. 305-629.9210 • geminidentaldoral.com