PRECISION PERIODONTICS & DENTAL IMPLANTS

Written Financial Policy

Thank you for choosing Precision Periodontics & Dental Implants. Our primary mission is to have a mutually satisfying relationship, which provides only the highest quality treatment in a warm and friendly environment. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You can choose from:

* Cash, Check, Visa, or Mastercard

* No Interest & Extended Low Interest Payment Plans from Care Credit

Please note, that Precision Periodontics & Dental Implants requires payment at time services are rendered, unless prior arrangements have been made.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for the reimbursement of your treatment.

A 50.00 per half hour fee may be charged for patients who miss or cancel appointments without 24 hours courtesy notification.

Precision Periodontics & Dental Implants charges $25 for returned checks.

Authorization For Submission Of Claims & Assignment Of Benefits

I, authorize Precision Periodontics and Dental Implants to submit claims for payment of services to the dental care service plans or insurance companies named below, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. **I understand that I am financially responsible for any charges not covered by the group insurance benefits.**

I authorize Precision Periodontics and Dental Implants to release to hospital or health care services plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my dental history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate and claim for benefits.

If my coverage is under a group master agreement held by my employer, an associate, trust fund, union or similar entity this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain in effect for up to five years from this date. I know I have the right to receive a copy of this authorization if requested.

I have read the Written Financial Policy & the Authorization for Submission of Claims & Assignment of Benefits and I, agree to comply with these policies.

_____ _____

Patient Name/ Guardian Name Date

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