Financial Policy:
Thank you for choosing our office as your dental health care partner. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time the service is provided. Our office accepts cash, personal checks, debit cards as well as all major credit cards. Outside financing is available upon request and approval with CareCredit.

Please note: returned checks will be subject to a $50.00 fee. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges.

A fee of $50.00/hour will be charged to your account for any appointments for which you are scheduled and fail to cancel within 24 hours.

Do You Have Insurance?
*As a courtesy to you we will help process all your 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. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make certain your estimate is as accurate as possible.

*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 has a contract between you, your employer, and your insurance company.

*Our practice is committed to providing the best treatment for our patients and we charge usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fee.

*We ask that you sign this form and any other necessary documents that may be required by your insurance company. This form instructs your insurance company to send payment directly to this office.

*We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time services are rendered.

We thank you for the opportunity to serve your dental needs and welcome any questions you may have concerned your care or our financial policy.

CONSENT:
I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to this dental office. The undersigned hereby authorizes Dr. Bethany Geyman and Dr. Cranfill to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Geyman to make a thorough diagnosis of my dental needs. I also authorize Dr. Geyman and Dr. Cranfill to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents and oral sedatives embodies a certain risk.
I understand that responsibility for payment for dental services provided in this office for myself or my dependents is due and payable at the time services are rendered.
I further understand that a finance, rebilling, collection charge, or attorney fee will be added to any overdue balance.

Print name: _____

Signature: _____**Date:** _____