GERIK DENTAL

Financial Policy

Thank you for choosing **Gerik Dental** for your dental needs. Our practice is committed to providing quality dental treatment for our patients. The following is a statement of our Financial Policy, which we require you to read and sign.

All patients (parents or guardians) must complete our Patient Registration form prior to seeing the provider.

- Your payment portion is due at the time of service
- We accept Cash, Checks, Visa, MasterCard, and Discover credit cards
- There will be a $30.00 charge on all returned checks
- All returned checks will automatically be turned over to Cornerstone Credit Services for collection

Regarding Insurance

Gerik Dental bills insurance as a courtesy to you. We need you to provide complete and accurate insurance information. Knowledge of your deductible and co-pays is your responsibility, not ours. We do not guarantee the accuracy of benefit information when quoted to us by your insurance company. If for any reason your insurance coverage changes, it is your responsibility to inform Gerik Dental in a timely manner. Please be aware that some, and perhaps all of the services provided may be non-covered services. Some insurance companies reduce or deny benefits saying they are not considered UCR (usual, customary, or reasonable). Please be advised that our fees are based on national geographic standard and are, in fact, UCR for Alaska.

All deductibles and co-pays are due and payable at the time of treatment:

Any balance on your account is your responsibility, whether your insurance company pays or not.

By signing below, you are authorizing the release of information to your insurance company so they may pay Gerik Dental Office directly.

If for any reason we have not received payment from your insurance company within 60 days from your date of service, you become responsible for the outstanding balance. At 90 days, your account may incur a monthly interest charge of 10% until paid in full. At 180 days, any outstanding balance may become subject to collections. If your account is sent to an outside collection agency, a 35% fee will be assessed.

Please help us to serve you and other patients better by keeping your scheduled appointments. If you confirm your appointment and do not show or call at least 24 hours prior to your appointment, a No Show Fee of $100 may be applied to your account, and must be paid prior to scheduling future appointments.

I have read, understand, and agree to this financial policy.

Signed: _____ _____

Patient or Responsible Party Signature — Patient or Responsible Party Printed Name

Relationship to Patient: _____

Patient Name: _____ Date: _____