

Dr. Kristen Gibson  Dr. Clara Felker

**Policy Agreement**

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

I understand that dental services furnished to me are charged directly to me and I am personally responsible for payment of all dental services. If I have dental insurance, I authorize my insurance company to pay directly to Dr. Kristen Gibson & Dr. Clara Felker, DDS.

As a courtesy to you we will gladly process your insurance claim. **Our responsibility is to provide you with the treatment that best meets your needs. Not to try to match your care with your insurance plan limitations.** We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately, with the information provided to us by you and your insurance company, we are able to provide some assistance in estimating your insurance benefit. We try our best to let you know what your approximate portion will be for treatment, but it is always an **ESTIMATE**, not a guaranteed amount. However, please know that your insurance company makes the final determination once treatment is completed and the claim is submitted. **Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.**

**We are considered an out of network dental office** – it is your responsibility as a patient to check with your insurance company to see if you are eligible to be an established patient at our practice.

If you do not have dental insurance then all services must be paid at the time of service. If needed we are happy to accommodate an agreeable monthly payment plan that will best suit you.

**I realize I am financially responsible for all charges incurred, regardless of insurance coverage.** I am aware that my account will go to a collections agency if agreeable payments have not been made after 90 days. I am responsible for all collection costs incurred by the dental office. All returned checks will generate a \$30.00 fee.

**No Show/Late Cancellation Policy** – Because instruments, chair time and personnel are reserved exclusively for your appointment, there is a **\$100.00 fee for broken appointments LESS than 48 hours in advance notice.** If you are unable to keep your scheduled appointment, we will honor **one** re-schedule at no cost to you if you contact our office within 48 hours of your appointment time. A second **re-scheduled** appointment will generate a \$50 deposit, which needs to be paid at the time of rescheduling. In the event that you have special circumstances regarding your missed/cancelled appointment, please contact our front office personnel. We understand that there are issues beyond your control.

**Late arrival** – If you are not able to make your appointment on time, please call our office to advise us of your situation and provide an estimated arrival time.

Printed Name of Patient and or legal guardian: \_\_\_\_\_

Signature of patient and or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_