Jeffrey C.H. Chow, DDS

Diplomate, American Board of Periodontology

Periodontics-Implantology

Greenfield Medical—Dental Center • 2450 E. Guadalupe Rd., Ste. 104, Gilbert, AZ 85234 • Ph. (480) 635-8787

Financial Policy Agreement

Please read and ask questions if you are unclear about statements.

A. Patients are required to make payment or estimated co-payment on the day services are rendered.

B. Predetermination and insurance billing are done as a courtesy for you. The remaining balance or co-payment portions from your primary insurance is due at time of service. If you have secondary insurance, that amount is due at time of service, but we will send a claim and have claim payment directed to you.

C. Your insurance is a contract between you and your insurance carrier. We are happy to work with you in attempting to obtain full benefits from that coverage. However, you are ***ultimately*** responsible for your balance.

D. Please note: Predetermination of benefits are NOT a guarantee of payment. Claims for payment will be processed by dental consultants and payments will be determined at that time. Any balance not paid by the primary and secondary insurance carrier will be ***the responsibility of the insured.***

E. Responsibility for payment for dental services provided in this office is due and payable at the time services are rendered. In the event of default you will be responsible for legal collection fees and any reasonable attorney fees as may be required to effect collection of past due accounts.

F. Time is important for us and for our patients. We strive to maintain punctual appointments. If a scheduled appointment is broken or no showed without a 48-hour notification, a $20 broken-appointment fee is charged. If you have scheduled for a surgery a 76-hour notification is necessary and a charge of $50 for the broken appointment will be assessed.

Our intent is to provide you with the best periodontal care, at the most reasonable cost possible. We thank you for your cooperation.

I have read and understand the above statements.

Patient's signature_____
(or responsible party – if patient is under the age of 18)

Patient's printed name_____Date_____
(or responsible party – if patient is under the age of 18)