GALLERIA DENTAL
FAMILY • COSMETIC • ORTHODONTICS
IMPLANT & GENERAL DENTISTRY

# Financial Policy

- I understand it is my responsibility to pay for all dental treatment provided in this office for my dependents and myself at the time of services, unless prior written arrangements have been made. In the event that payment is not received on the agreed upon dates, I understand that **a 2% finance charge will be added to my account for the service date of the treatment.**

- I understand that my insurance coverage is a contract between my insurance company and myself. **Not all services are a covered benefit with my insurance**.

- I understand that any procedures not covered by my insurance become **my financial responsibility** as well as to dispute any coverage between **my insurance and myself.**

- I understand that Galleria Dental accepts cash, all major credit cards, personal checks, and financing from Care Credit.

- I understand that a **$35.00 Non-sufficient Funds Fee** will be added to my account if a **returned check** is received from my bank.

- I understand that in the event my account needed to be assigned to an outside **collection agency, a 30% collection** fee based on the balance will be added.

- I understand that a $**50.00 Broken Appointment Fee** or more may be added to my account if I fail to provide at least two business days notice for cancelled or rescheduled dental services.

- I understand that it is my responsibility to advise the office of any changes in the information regarding my patient information, insurance and health history.

- I understand that a $**25.00** fee may be applied to my account for **duplication of my dental records and xrays.**

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**Patient Name (print) Date**

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**Patient Signature – Date**