702DENTIST®

GLEN A. GALLIMORE, D.D.S. LLC.
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INSURANCE INFORMATION AND FINANCIAL POLICY

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

INSURANCE PATIENTS

As a courtesy we do our best to verify your eligibility and benefits available to you. This is ***not*** a guarantee of payment. It is the patient's responsibility to ensure correct and complete insurance is given to our office on or before the date they are to be seen. Our office will ***estimate*** your co-pay prior to treatment based on the information obtained from your insurance company. Your co-pay is expected at the time of service. **If payment from your insurance company is not received within 90 days from the date of service, you will be expected to pay the balance in full.** Please understand after your insurance processes the claim there may be a remaining balance left on your account. **The remaining balance is due and payable upon receipt of the statement.**

I hereby authorize **Glen A. Gallimore, D.D.S**. to release to my insurance company, information acquired in the course of my care. I hereby authorize benefits to be paid directly to **Glen A. Gallimore, D.D.S.** I understand that I am responsible for any unpaid balance.

I understand an estimated portion is due at the time of service, however if my account has a remaining balance after the insurance processes my claim I authorize Glen A. Gallimore, D.D.S. to charge the balance to my credit card.

_____ _____

Patient/Parent Date Policy Holder's Signature Date

ALL PATIENTS

For patients who do not have insurance coverage payment is expected in full at the time of service.

We accept Visa, MasterCard, cash, or checks with a valid state issued driver's license or picture I.D. card. Financing is offered through Care Credit which offers interest free periods, low monthly payments, and comfortable payment plans. Please request an application for instant financing.

A $25.00 fee will be charged to all patients who do not give a 24 hour notice prior to rescheduling or canceling. Returned checks are subject to a $25.00 fee. Unpaid account balances older than 60 days will be charged a service charge and a monthly interest charge of 2.2%(26.4%APR). Unpaid account balances older than 90 days may be turned over to a collection agency and a 43% collection fee will be charged to the account.

_____ _____-_____-_____

Printed Name of Patient Patient's Date of Birth Patient's Social Security #

_____ _____-_____-_____

Printed Name of Responsible Party Responsible Party Social Security #

_____ _____

Address Responsible Party Phone Number

_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

_____Initial that you have received our HIPAA Notice of Privacy Practices.