



John Gallop, D.D.S.
512-336-8478
512-DENTIST

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities. Please read, sign and return the following:

Payment

Payment in full is due at the time of service unless prior financial arrangements are made. Payment for services for the treatment of minors is the responsibility of the adult accompanying that minor. We offer several payment options including cash, checks, Visa, MasterCard, and Care Credit.

Dental Benefits

Our office is committed to helping patients maximize their benefits. Benefit policies vary greatly; all include annual maximums and limit how often some treatments will be reimbursed. In cases where benefits cover less than our treatment fee for any reason, you are responsible for paying the difference. We can estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of benefit contracts. Your benefits are an agreement usually between your employer, your benefits carrier, and you; we are not a party to that agreement.

Your estimated patient portion must be paid at the time of service. As a ***courtesy*** to our patients, we will bill benefits companies for services and allow them 45 days to render payment. Sixty days after treatment you are responsible for the entire balance, due in full. We will continue, to the best of our ability, to assist you in recouping benefits from your benefits provider. If you have any questions, our friendly staff is always available to answer them.

Missed Appointments

Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge \$50 per hour for all cancelled or missed appointments without two business days' notice.

Service Charges

The policy of this office is to charge 1.5% interest monthly (18% annual percentage rate) to all account balances more than 70 days after treatment. We will charge \$30.00 for returned checks.

Collection Fees

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

Assignment of Benefits

By signing this Financial Agreement, you, the patient, agree to have all benefit payments paid directly to Gallop Family Dentistry.

I understand and agree to the above stated Financial Policy.

Signature of Patient/Responsible Party

Date