Gables Dental Care Office Policy

It is our policy to receive payment in full the day services are rendered. We accept cash, checks, MasterCard, Visa, American Express, and Discover.

If you are insured, by signing this agreement, you assign benefits to this office. Most plans do not cover 100% of the cost of treatment, because of this, and the extreme delay in receiving payment from insurance companies; you must pay your portion of the charges **on the day** the services are rendered. We will assist you in dealing with your insurance company, but the ultimate **responsibility lies with you**. Please note this is not a guarantee that claims will be paid. Payment is subject to eligibility at the time the claim is processed. All benefits are subject to the terms and conditions of your plan.

*There will be a **$35.00** charge for all checks that are returned. No other checks will be acceptable as payment on your account if you give us a **NSF check**. All payments will be accepted as cash or credit card or debit charge.*

AFTER 60 DAYS IF THE BALANCE HAS NOT BEEN PAID IN FULL, IT WILL BE DUE FROM YOU, AND WE WILL BE SENDING YOU A BILL WHICH WILL BE DUE UPON RECEIPT.

FAILED APPOINTMENTS AND CANCELLATIONS POLICY:

The time set aside for a patient is very valuable to Dr. Aran. We understand that sometimes an emergency arises that we cannot control. With that being said, if you cannot keep an appointment, please notify us a minimum of *24 hours in advance*. A charge of *$30.00 will be applied* for each broken appointment. If you miss 3 appointments without prior cancellation we reserve the right to dismiss you from our practice during which at that time you will only be seen for emergencies during a 30 day period, giving you due time to find another dental provider.

If you are more than *15 minutes late*, you will be re-scheduled for a later date.

APPOINTMENT CONFIRMATIONS:

Our office may confirm your dental appointments through email or through text messaging. Please provide us with this information if you wish to confirm your appointments this way. Rest assured that ***we do not sell your information to any third party companies. This is for our records only.***

Email: ______________________________ **Cell phone:** ______________________________

Financial Agreement

The undersigned agrees, whether he/she signs as guardian, agent or as patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay their account. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all reasonable attorney fees, collection expenses and court costs. The undersigned further agrees to pay late charges if this account goes delinquent.

Patient/Guardian Signature: ______________________________ Date: ______________

If you choose to transferred to another dental office, or need a copy of your records,
There will be a ***duplicating fee of $30.00***