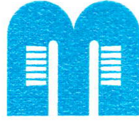

Roxanne Malone, D.D.S.
Gentle Family Dental Care

Office Financial Information

Thank you for choosing Dr. Malone as your dental care provider. We are committed to giving you gentle, quality treatment. We have asked that you complete our medical and dental history forms so that we can give you the best care possible. We now ask you to read and sign our financial policy so that there is no confusion regarding fees in our office.

PAYMENT IS EXPECTED AT TIME OF SERVICE

Our financial options for your convenience are:

A 5% courtesy discount will be extended to you for the treatment plans over $2500.00 if paid in advance with check or cash only.

We offer Care Credit for extended payments, we accept Mastercard, Visa, Discover and American Express for your convenience.

If you have insurance, please provide us with your card so we may photocopy the information and confirm your eligibility and benefits. With confirmation of eligibility and your authorized signature on file, we will gladly file your insurance claim. We will ask you for your deductible and the estimated patient portion of the total charges. We can make no guarantee of the insurance company's amount of payment. Claims are submitted promptly after treatment is rendered, if the patient's insurance company has not paid by the 61st day after treatment, the patient will be billed in full. If you have a secondary insurance, we will file the claim for you however payment is expected when services are rendered. We will ask the secondary insurance company to pay the patient directly. Our office prides itself on helping our patients maximizing their benefits and we are always available to answer your questions.

PERSON RESPONSIBLE FOR ACCOUNT:

Name:______________________________ Relationship to patient:______________________

Address:_____________________________ City:________________State:________Zip_______

Home:______________________________ Work:_________________________________

I hereby authorize payment directly to Roxanne Malone, DDS, PA of my insurance benefits
____

Signature of file

I agree to be fully responsible for total payment of procedures performed by Dr. Malone, including any portion not covered by my insurance company. I agree that should this account be referred to an attorney or agency for collection that I will be responsible for all collection costs, attorney fees and court costs.

I, the undersigned, have read the above and assume responsibility for my account.

Signature:__________________________________ Date:________________________

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