WELCOME TO OUR OFFICE

Thank you for choosing our office. We appreciate your trust in us and we will do everything we can to take care of your dental needs.

In order to accommodate both insured and uninsured patients we use the following guidelines. **Please read and sign.** Your signature will indicate your understanding and acceptance of the following terms.

INSURED PATIENTS:

Payment in full is due when services are rendered. However as a courtesy we will gladly file your primary insurance for you with benefit payment assigned to our office- any remaining balance is your responsibility. Please be aware that most dental insurance polices never pay 100% of every dental service. Below is an example of a typical dental plan:

1.) Preventive Services: 90% to !00% coverage usually includes, teeth cleaning, exams, and x-rays

2.) Basic Services: 80% coverage usually includes fillings, extractions, root canals, and some types of teeth cleaning

3.) Major Services: 50% coverage usually includes crowns, dentures, and partial dentures

4.) Annual deductible usually is $50.00 with a yearly maximum amount of benefits at $1000.00 to $1200.00 paid

These are generalizations, you must consult your individual plan for specific details of your policy. Even if you have insurance you most likely will have a balance due.

UNINSURED PATIENTS:

Payment in full is due when services are rendered. If a payment plan is necessary please let us know in order to establish terms before beginning treatment.

AGREEMENT TO PAY

I acknowledge and agree that I am responsible for and will pay for all regular charges, services, and treatments provided to me including any amount not paid by my insurance plan.

I understand that services that Paul L. Gilliam, D.D.S. or staff may provide to me may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered services in excess of the limits in my member benefit agreement.

If a delinquent account is refereed for collection, I agree to pay the reasonable attorney's fees, court cost and/or collection agency fees associated with the collection process. Please note some collections agencies charge as much as 40% of the balance due.

I have read this agreement or have had it read to me. I have provided accurate information. I understand that I am personally responsible for payment and for any and all items or services not covered by insurance. By voluntarily signing this agreement, I accept and agree to comply with its terms. I understand that if I have any questions or need to change my payment arrangements, I should ask the office staff.

_____ Date_____

Signature of Patient

_____ Date_____

Signature of Legal Representative

Relationship to Patient: _____