Gentle Dentistry P.A.
Christine Hoang D.D.S.
4931 W. 6th St. - Suite 114
Lawrence, KS 66049

Financial Policy

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

1. Payment is due at time of service
2. We accept cash, check, MasterCard, VISA and Discover.
3. If insurance is involved, co-payment and any deductible is to be paid at the time services are rendered.
4. Failure to adhere to agreed upon payment arrangements will require full payment of current charges and advanced payment of any future services.
5. The parent or guardian who accompanies a minor child to the appointment is financially responsible for the account.

I understand and agree:

1. Services shall be paid promptly in accordance with terms and agreements.
2. 1.5% per month will be added to charges on accounts not paid within sixty (60) days after the date of the initial statement for those charges. For comparison purposes, this periodic rate equals an ANNUAL PERCENTAGE RATE OF 18%.
3. In the event of default to pay, collection charges and/or attorney fees will be applied.
4. There is a $25 assessment fee for each returned check.
5. There is a $40 failed appointment fee if 24 hour advanced notice is not received.

We file insurance as a courtesy to our patients. Insurance is a contract between you and your insurance company. Your benefits depend on what you or your employer negotiated with the insurance carrier, and the amount of money you chose to pay in premiums. We will not become involved in disputes between you and your insurance regarding deductibles, co-payments, covered charges, and secondary insurance or other matters regarding reimbursement.

It is impossible for us to have complete knowledge about the numerous dental insurance companies' contracts with employers, or your status with your particular company. However, at the time of your initial appointment, your portion of the fee can be estimated and paid at the completion of that appointment. If the insurance payment varies from the computed amount, an adjustment will be made.

I understand that I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay. This signature will also serve as signature on file for assignment of insurance benefits.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____