PRACTICE PHILOSOPHY AND FINANCIAL POLICY

Our mission is to provide your family with the finest available Comprehensive, Family Dental Health Care. We aim to provide you with a relaxing visit utilizing comfortable, state-of-the art technologies. We have developed affordable services, when performed on a timely basis, can avoid more costly procedures later. For your convenience, please review our practice financial policy. This will provide you with clarity in the financial administration and payment of dental costs to the practice as you are treated. We want to take just a moment to explain some of the steps necessary in a successful dental health relationship.

APPOINTMENTS ARE DESIGNED SPECIALLY FOR YOU!!

We make a special effort to provide you and your family with a unique health experience. This involves reserving a specialized time for you and your family to receive premium care. Should you have to rearrange your appointment, please let us know 48 hours in advance. With the rising cost of health care, these scheduled times are very expensive. If you fail to keep your appointment WITHOUT advance notice, you may be responsible for a $50 fee/half hour.

DENTAL INSURANCE

We may request payment-in-full at the time of service. If you have dental insurance benefits, we will gladly assist you with processing your claim. Often, insurance plans do not provide what is expected, do not provide us with covered fee information, and usually require a family deductible due in addition to benefits provided by your plan or insurance carrier. **Our office is OUT OF NETWORK with all insurance plans except Delta Dental PPO and Cigna PPO (excluding Advantage).**

_____ I am aware that Enterprise Dental Care is out of network with dental insurance

PAYMENT POLICIES

Payment is expected as treatment is rendered unless alternate arrangements have been made in advance with our treatment coordinator. We accept VISA, MASTERCARD, DISCOVER, and PULSE CARD as well as Personal checks and Cash. A Senior Citizen Courtesy is extended when payment made at the time of service. If either of these methods can not be arranged in order to meet your expenses, we can assist you with financing through a third party financial services firm, Care Credit or Capitol One**, however, this must be in advance of your visit. **A nominal processing/ application fee may accrue with a third-party financial firm.

AUTHORIZATIONS

I, __________________________, hereby authorize **Kevin C. Granger D.D.S** to apply for benefits on my behalf for services rendered to me (or my minor child) and request that payment be made by __________________________ Insurance Company and that payment be sent directly to **Kevin C. Granger D.D.S**

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me (or to my minor child), and if my account is turned over for collection, I agree to pay all reasonable legal fees (*30% is deemed reasonable*) and collection fees. If suit is filed I agree to pay reasonable Attorney's fee (*33.3% is deemed reasonable*), court costs, and other expenses incurred as a result of said collection. The undersign agrees that should suit be filed, venue (location of suit) shall be in Prince George's County, Maryland, venue in any other counties being waived hereby. It is further understood, that overdue accounts will be charged interest at the annual rate of 18% (1.5 per month).

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim for benefits, in order to process and claims for benefits. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by you at any time in writing.

____	___________________________
Patient Name (printed)	Date
____	___________________________
Account Guarantor Signature	Date