Gateway Dental
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Phone: (703) 736-0333

EXPLANATION OF OFFICE & FINANCIAL POLICIES

Welcome to Gateway Dental. We are committed to providing you with the highest level of services and quality of care. If you have insurance we will strive to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and understanding of our office and financial policies.

FINANCIAL RESPONSIBILITIES: For our patients with dental insurance (Indemnity and PPO) coverage: We will be glad to help you obtain the benefit information for your insurance plan and bill your carrier as a courtesy to you. You are responsible for the co-payment which is the difference between our fee and the amount paid by your insurance carrier at the time of service. (Even if you have double coverage, there may still be a portion that will be your responsibility.) All copayments are due at the time of service. ________
initial

Please remember that dental insurance benefits are based on a contract between you and the insurance carrier. You are ultimately responsible for your account. We allow 60 days for claims to process.
If your carrier does not pay what is expected within 60 days of billing you are responsible for the account balance. ________
initial

For our patients with an HMO dental plan: This type of plan encourages prevention and early detection of dental problems. Therefore, as a member you are entitled to diagnostic and preventive services at minimal or no charge. This may include exams, x-rays, and some basic preventive dental procedures. Other procedures, almost without exception, require the member to pay a reduced fee. The fee or co-payment is determined by your plan type. Our staff will be glad to explain these co-payments determined by your particular plan. Details of your benefits are best provided by the member services department of your benefit plan. In the event your HMO plan determines that a service is not a part of your benefits, you will be responsible for our usual and customary fees. You must be assigned to our office (prior to your first appointment) to be entitled for reduced fee schedules. I understand that Gateway Dental will file claims for insurance benefits and accept payments per contractual agreements with participating insurance companies. Knowing the terms, imitations and guidelines of my health insurance policies is my responsibility as a patient. I assume all financial responsibilities for my charges incurred as a result of policy termination, or coordination of benefits or limitations otherwise not mentioned that result in non-payment. We allow 60 days for claims to process, after which time the balance becomes your responsibility. ________
initial

PAYMENTS, OVERDUE ACCOUNTS, AND INSUFFICIENT FUNDS: Payment is required for all dental care at the time of service.

Should any balance arise due to insurance copayments, coinsurance, deductible, insurance denials, termination of coverage for any reason, I agree to pay all charges within 60 days of services rendered. ________
initial

Accounts due greater than 90 days are subject to an 18% annual service charge. In addition, if your account is referred for collection, you will be responsible for an additional 33 1/3% attorney fees. Checks returned by your bank are subject to a $30 bank processing charge in addition to the amount of the returned check.

REPORTING NEW INFORMATION: Communication is the key to a successful relationship and this may also be applied to your relationship with our office. Kindly inform us of any changes in your insurance coverage prior to your appointment, address and phone number changes, or medical history.
Our preferred method of contact is through email. Please provide an email address that we may use to communicate with you. ____ @ ________________ .

CONFIRMING YOUR DENTAL APPOINTMENT: Please note your appointment time carefully; this time has been reserved exclusively for you. As a courtesy, the office will make every effort to remind you of your appointment, one week to 48 hours before your appointment, however confirming or cancelling appointments is the patients responsibility. Any appointment not confirmed by 10 am the day prior to your appointment, will be removed from the schedule. There will be a $75 fee for missed appointments, or any appointment not cancelled 48 hours prior to your scheduled appointment. ________
initial

KEEPING YOUR APPOINTMENT: Missed appointment times affect many people. The doctor and staff are prepared for your treatment and patients who have been waiting for treatment could have been seen at this time. Please be considerate and call the office to notify us of a cancellation at least 48 hours in advance. We understand that your time is important and we work hard to stay on schedule. Occasionally, emergency procedures cause us to be delayed and we apologize in advance. **There is a $250 fee for any periodontal procedure not cancelled 7 business days prior to periodontal surgery appointment**. ________
initial

REQUEST FOR RECORDS: All patient records are the legal property of the doctor, however, we will gladly provide you with the copies of your x-rays one time, at no cost. In accordance with your dental plan and state guidelines, there is a fee of $45 for any additional request of x-rays or records. Treatment records are computerized and we will gladly provide you with a complete listing of services performed upon request. ________
initial

TREATING OF MINORS (UNDER 18 YEARS OF AGE): All patients under the age of 18 must be accompanied by an adult who must remain in the office during the duration of the treatment. Children who are "dropped off" for treatment by a parent or legal guardian will not be seen. Please note that legally we are not able to make any exceptions to this policy. **You may not leave your child/children unattended while you are receiving treatment.**

RECOMMEND TREATMENT MAINTENANCE: Although the office may assist you with reminder letters or telephone calls, it is your responsibility to complete the treatment and to follow the recommended treatment maintenance program. Once a new crown, bridge, denture or partial has been started, it is the patient's responsibility to return within the recommended time for treatment completion. If you require that the crown, bridge, denture or partial be remade because of your failure to return to the office for treatment, you will be responsible for all previous charges and all additional charges involved in the remaking.

The above information is intended to provide clarification and prevent future misunderstanding. I have read the above and understand the office policies and agree to pay the fees established by the office or by my dental benefit plan.

Printed Name Date	Patient/Guardian
Signature	Signature