



David M.
Glasscock DDS
FAMILY & COSMETIC DENTISTRY

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. As a courtesy to our patients, we file insurance claims for dental services performed in this office. Although, we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You, the patient, will be financially responsible for any services provided that are not covered by your insurance company and for any fees that are above the amount payable by your benefits program. In cases where conflicts arise over reimbursement, denial of claims, or proposed treatment it is recommended that you involve the employer in order to find an appropriate solution.

Required Payment: For all services payment of (coinsurance & deductibles) is required at the time of treatment. An estimated portion will be calculated from what your insurance company has given us in percentages; this is merely an estimate. Please be aware, if there is a balance remaining after your insurance pays, you are responsible for the remaining portion that your insurance company did not cover. If we are covering for another doctor we will submit to the insurance however, payment in full will be required and reimbursement will be sent directly to you by the insurance company.

Statements: Unless, Dr. Glasscock approves other payment arrangements, the balance on your statement (s) is due and payable when the statement is issued. The balance will be considered past due if not paid by the end of that cycle month. If balance is not paid an additional financial fee will be added to your account of 18% APR. for every month that the balance remains.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If a payment plan is set up, you the patient or responsible party, agree to have any missed payments put on your credit card to keep the account in good standing. If we have to refer your account to a collection agency, you agree to pay all collection costs that are incurred. If legal action is required, you agree to pay all legal fees, court costs, and attorney fees as well as interest being accrued for all accounts that have outstanding balances.

Returned checks: There is a fee \$35 for any checks returned by the bank.

Missed appointment fee: There will be a \$40 per hour reserved fee for missed appointments with less than 24 hour notice. Also, appointments that are 2 hours and over will need a 48 hour notice to cancel. If appointment cancelled less than 48 hours the fee of \$40 an hour per hour will be charged. This fee must be paid before any other appointments are scheduled. Patients with 3 missed appointments will be asked to transfer their records to another dentist.

I have read and fully understand this agreement. I agree to the terms and conditions contained herein. I have also reviewed the Notice of Privacy Practices and understand that I may have a copy to take with me.

Patient's Name: _____ Date _____

Responsible Party (if not the patient) _____ Date _____

Signature _____ Date _____