Patrick R. Gallagher III D.D.S
Lawrence S. Eden D.D.S
715 Baltimore Blvd Westminster MD 21157
410-848-3866 or 410-857-5660

Financial Policy and Informed Consent

Thank you for allowing us to assist with your dental health. Our office is committed to having your treatment be a positive experience. It is our belief that all people who entrust their oral health to us want and deserve the finest dental care that we are capable of providing. Please understand your financial obligations are considered part of your treatment. Our purpose in providing you this financial information is to acquaint you with our policy for our mutual benefit. We will give you an estimate of costs required in advance of treatment so that you can come prepared for each visit. Please read the following and sign before being seen.

1. **Full payment is due at the time of services unless prior arrangements are made.** A 5% courtesy will be given to patients having crowns, bridges, dentures or partials that pay in full before service is rendered or at the time service is performed. (This does not apply if you are using Care Credit or insurance that already offers a reduced fee.) Other payment options include credit card (Visa, Master Card, American Express or Care Credit.)

2. The following applies to those patients with insurance:

a. If we are unable to verify your dental insurance, cannot obtain a list of benefits, or determine that your insurance will not assign benefits to our office payment in full is due at the time services are rendered.

b. If your insurance company will assign benefits to us, then patients are asked to pay their deductible and estimated payment at the time treatment is rendered.

c. While filing your insurance claims is a service we extend to our patients, we must emphasize that as dental providers, our relationship is with you, our patient, not the insurance company. In the state of Maryland insurance companies are required to send payment within 30 days. If a full payment is not received from your insurance carrier within 60 days, the balance becomes your responsibility and will be subjected to a billing charge.

d. The insurance information we receive is limited to only covered procedures. We sincerely encourage you to contact your insurance company to obtain a list of procedures and limitations not covered by your insurance.

e. Due to the uncertainties of responsibilities and relationships between your primary and secondary insurance carriers, in some instances we will not be able to file secondary dental claims. However, we will provide you with a detailed computer generated insurance form that you can submit for reimbursement.

3. **Minor Patients:** Must be accompanied by a parent or guardian for all appointments unless a written consent is provided. The adult accompanying the minor is responsible for the payment. Initials______

4. **Missed Appointment:** Your scheduled appointment has been reserved at your request. If this time becomes inconvenient for you, please call our office at least 24 hours before that scheduled time or a broken appointment fee of $10.00 a unit may be charged. If you have an appointment that is over two hours in length we do ask for a 48 hour notice. Payment of the broken appointment fee may be required prior to reserving subsequent appointments. Initials______

5. **Past Due Account Fee:** There is a $35.00 fee charged on all returned or stop payment checks. Account balances older than 30 days are subjected to a monthly billing charge of $3.00. Any balance older than 90 days may be forwarded to "Collections" and subject to additional fees, including, but not limited to, a collection fee (33% of the balance), attorney's fees, and court costs. . Initials______

6. **Assignment of Benefits:** I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy to the Dentist. This form also authorizes the practice to submit insurance claim forms and receive payment directly from the insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist (s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested. . Initials______

7. **Consent for treatment:** I hereby give consent to the dentist and/or his designee(s) for the performance of any diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I further authorize the performance of all recommended treatment and therapeutic procedures to include administering medications as prescribed by Drs. Gallagher and Eden and mutually agreed upon by me. I understand that no guarantee or assurances have been made as to the results that may be obtained. Initials______

I have read the above policies and agree to abide by them.

Print Name(s)________________________________

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Sign Patient/Guardian if under 18 Date