



MATTHEW LAHAIR, DMD

F. EDWARD GALLAGHER, DMD

FINANCIAL & APPOINTMENT POLICY

PAYMENTS:

Payment is expected on the date of treatment. We accept cash, check, Master-card, Visa, and Discover.

INSURANCE:

As a courtesy, we will submit charges for treatment to your insurance company. Whenever possible, we will also submit pretreatment estimates to give you a more accurate idea of your dental coverage. You are expected however, to satisfy our co-payments and deductibles on the date of services rendered.

We must have a valid insurance card or form in order to submit claims. Should you not have either you will be responsible for the entire amount at the time of the appointment.

We will assist you with understanding your policy as much as we are able. Please be advised that insurance companies change constantly and that you need to be responsible for knowing your own insurance coverage.

Your insurance carrier has 45 days to pay or deny your claim. If a problem occurs, we will ask for your assistance in contacting your insurance company.

We expect all patients with an outstanding balance to remit payment in full within 30 days **OR** make a payment arrangement plan with our Billing Department. We will make every effort possible to offer a payment plan satisfactory to all of us. Failure to remit payment or contact our Billing Department within 30 days will result in your account being sent to our Collection Agency. If your account is sent to Collection, the collection costs will be added to the balance due.

DIVORCE DECREE:

This office is NOT a party to your divorce decree. The responsibility of the bill is with the parents or legal guardian.

APPOINTMENTS:

We **respect your time** and schedule appointments that work best with your schedule. We ask that you **respect our time** and give us a **minimum 24 Hour notice** to cancel or reschedule any appointments. A **minimum fee of \$25** may be charged for missed or cancelled appointment **at the office's discretion**.

As a **courtesy** we confirm appointments **24 Hours in advance**.

I have read the **Financial & Appointment Policy** of Dr. Lahair and Dr. Gallagher's office.

Signature: _____ Date: _____