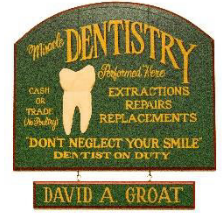


David A. Groat, D.D.S.

Our Financial Alliance

Our Philosophy
It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through final payments, to be perceived as an extension of the dental care we provide you and your family.

Patient's Role
As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

Requirements:

- All information forms must be completed.
- All estimated patient portions are due at time of services.

Forms of payment:

- Credit Cards: Visa, MasterCard
- Cash
- Personal Check

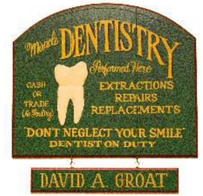
Extended Payment Plans with Credit Approval:
CareCredit www.carecredit.com 800-677-0718

Regarding Insurance
As a service to our patients we will file and take assignment of your insurance benefits. We will carefully estimate your personal investment for your dental care and make every effort to maximize your dental benefits. **This is an estimate only.** We cannot make any guarantees as to your insurance coverage. It is impossible to determine what the actual benefit for any service will be. **All deductible, co-pays, unpaid insurance balances are the responsibility of the patient/responsible party.**
Please review and sign the Dental Insurance Disclaimer.

Thank you for understanding our Financial Alliance. Please let us know if you have any questions or concerns.
I have read the Financial Alliance. I understand, accept, and agree to this Financial Alliance.

____
Signature of Patient or Responsible Party Date

____
Print Name of Patient or Responsible Party Date



David A. Groat, D.D.S.

Dental Insurance Disclaimer

Please understand that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment, we at no time guarantee what your insurance will or will not do with each claim.

Our goal is to help you maximize your dental insurance benefits. We are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and reimbursement may vary according to your individual plan when the actual claim is submitted. Any treatment plan that our office proposes to you is an **estimate** of your insurance coverage it is **not** a **guarantee.** We will always work to maximize your insurance benefits for you.

Please remember that the contract itemizing your dental benefits is between you, your employer and insurance company. Although we call and get benefit information for you we suggest that you call your insurance company to confirm any waiting periods, deductibles or benefits payable concerning your treatment plan. Regardless of coverage, your **estimated co-payment is due in full the day of treatment.** If your insurance plan does not pay within 60 days of treatment, you must pay and outstanding balance and seek reimbursement from your dental plan. Also remember dental insurance plans are not designed to cover all of your dental needs.

To Read and Sign

I have chosen to allow Dr. Groat to file my insurance and I do accept full responsibility for this account and for all dentistry performed upon my family in this dental office. **I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits.** I also understand that if my insurance company does not pay within 60 days of my date of service then I will become responsible to pay at that time.

Print Name ______________________________________Date ___________________

Patient Signature ____

Staff Signature ____

The known limitations of my plan have been reviewed and applied to this estimate.

Staff Initials __________________   Patient Initials _________________