ALEXANDER L. GILL, D.D.S., P.A. ~ OFFICE POLICY

Thank you for choosing us as your dental care provider. We are committed to the success of your treatment. The following is a statement of our Office Policy, which we ask that you read, agree to and sign prior to treatment.

Payment in full is expected at the time of service. However, as a courtesy we accept assignment of benefits from most insurance companies. We also accept MasterCard, Visa, American Express & Discover and CitiHealth Card.

PATIENTS WITHOUT INSURANCE
Payment is expected at the time of service, using cash, check, credit card or CitiHealth Card financing.

PATIENTS WITH INSURANCE
If you do not have your insurance card/benefits booklet with you, we will file the claim but we ask that you pay for services today. Dental insurance polices are contracts between patients and their insurance companies. As a courtesy, we accept assignment of benefits from most companies.

Any ***estimated*** benefits quoted are based on ***limited information*** obtained from your insurance and may not be the actual amount covered. Our charges are within the "usual and customary" range of ***most*** carriers but ***not all*** - since this range varies with each insurance plan.

Your ***estimated*** portion of the bill is due at the time of service. You are responsible for the total treatment fee. We allow 60 days for your insurance to reimburse us. After this, all inquires to your insurance company or payments due become your responsibility - ***It is your responsibility to make sure your insurance company pays us on time.***

NEW PATIENT EMERGENCY VISITS
We require payment in full at the time of service. We will file your insurance for you and any reimbursement will be sent to you.

MINORS
A parent or guardian must accompany a minor. The parent or guardian accompanying a minor is responsible for payment. ***We cannot bill an ex-spouse, etc. for payment.***

MISSED APPOINTMENTS
Unless canceled at least 24 hours in advance, we reserve the right to charge $25 for missed appointments. Excessive broken appointments may result in dismissal from our practice.

BILLING CHARGES
A monthly billing charge of $7.00 will be applied to all outstanding balances after 30 days. If your balance is outstanding, all future services must be paid in full. Any insurance reimbursement will be applied to your balance. Delinquent balances may be turned over for professional collections after 65 days with a *35% collection fee* added.

RETURNED CHECKS
There will be a $25 fee charged to your account and we reserve the right to refuse personal checks in the future.

CREDIT CARD PAYMENTS
Monthly payments can be billed to your credit/debit card. Ask us for the proper forms.

In accordance with state law Dr. Gill is *held accountable and has a moral obligation* to his patients. Therefore it may be necessary to have x-rays, photos or study models done to make a *complete* diagnosis for treatment.

By signing below, I authorize dental benefit payments to be paid directly to Alexander L. Gill, DDS, PA from my insurance company, if applicable.

I have read, understand and agree to the above policy and agree to indemnify *Alexander L. Gill, DDS, PA* for all expenses that may be incurred in order to enforce collection of any amount due under this agreement. I also agree to pay reasonable attorney's fees and court cost incurred in such collection.

Signature of
Patient or Responsible Party: ______________________________ **Date:** ________________