GIBBERMAN DENTAL

FAMILY, COSMETIC & IMPLANT DENTISTRY

Dear Patients,

All of us here are committed to providing you and your family with quality dental care. We feel a clear understanding of your responsibilities is essential to the wellbeing of our relationship. If you should have any questions please feel free to ask.

Cancellation policy:
If you are unable to keep your appointment, we kindly ask that any cancellation or rescheduling of an appointment requires at least 24 hour notice by phone, fax or email. This courtesy on your part will make it possible for us to give your scheduled appointment, including hygiene recall appointments, to another patient in need of dental treatment. Patients will be billed a minimum of $99.00 for late cancellations or no-shows without proper notice. In addition, if you are running late for an appointment, more than 15 minutes, your dental appointment may have to be rescheduled and a late/no-show fee will be assessed accordingly. We greatly appreciate your confidence in our office and look forward to serving your oral health needs.

Patients with dental insurance coverage:
Please provide us with a current insurance card, and notify us of any changes. We will contact your benefits provider to verify coverage and request a breakdown of your dental benefits.

We will do our best to explain your coverage to you. Your copay is due at the time of service. We will file claims and accept payments from your benefits provider on your behalf. Claims denied twice will become the patient's responsibility. It is the patient's responsibility to keep up with insurance benefits remaining, although we will help you with this to the best of our ability.

Return checks are subject to a $45.00 returned check fee.

Please read the following carefully and sign where indicated. If my account is turned over to an attorney for collections, I understand that I will be responsible for <u>any</u> additional fees added to my account, including, but not limited to broken appointment fees, billing and service charges, late fees, legal fees and court costs.

Patient Name: _____

Guardian/Responsible Party (if minor): _____

Signature: _____ Date: _____