Groover Family Dentistry

The following is a statement of our financial policy for services provided within our office and do not apply to any testing, diagnostic procedures performed outside of the practice, or referrals to any specialist. We require you to read and sign and initial this document prior to treatment in our office.

Patient Responsibility

Insurance-All professional services rendered are charged to the patient and are due at the time of service. As a courtesy, this practice will file your claim with your insurance carrier: however the patient or responsible party is ultimately responsible for the charges not covered by your contract with your insurance carrier. If the claim is not paid within 45 days, the balance becomes the responsibility of the patient. Initial_____

Insurance-Insurance carriers typically do not cover all dental costs. Some pay fixed allowances for each procedure and office visit while others pay a percentage of the cost. It is the patient's responsibility to understand their insurance coverage. Initial_____

Due to insurance regulations, co-pays are due at the time of service. If there is no insurance balance is due at the time of service. Initial_____

When you receive a statement, you are requested to pay the balance in full upon receipt of the statement. If for some reason you do not agree with the balance due amount you are requested to contact our office at 912-354-9541 Initial_____

I understand that I am required to give 48 hours notice to cancel my appointment and that broken or missed appointments may result in a $37.00 fee per appointment. Initial_____

I understand that I am financially responsible to the practice of Groover Family Dentistry. If my account becomes past due and has to be turned over to a third party collection agency, there will be a collection fee added to my balance of 35%. Initial_____

_____ _____ _____

Patient Name (please print) Signature of Patient/Responsible Party Date

Assignment of Insurance Benefits

I hereby assign and authorize my insurance benefits to be paid directly to Groover Family Dentistry.

_____ _____ _____

Patient Name (please print) Signature of Patient/Responsibility Party Date