

ADVANCED CARE DENTAL

THERESA GARDOCKI, DDS
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OREGON, WI 53575

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Complete
Dental Care
for the
ENTIRE
Family!

FINANCIAL POLICY

We look forward to providing you with expert and affordable dental care. Our fees are based on the cost of providing you the best possible care. As a courtesy to you, we submit claims to your insurance may base its allowances on a fee schedule that may or may not coincide with our fees. You are responsible for the differences in costs as well as any deductibles, co-insurance pays and balances not paid for by the insurance company.

For us to provide the best possible dental care, we must be financially sound. Therefore, we require you to read, agree to and sign our financial policy as stated below.

INSURANCE

Your insurance policy is a contract between you and the insurance company. We will help you maximize the insurance benefits due to you, but we are not responsible for knowing your benefits or coverage. These benefits are set by the policy you have. Our financial policy is between you and this dental office. It is our experience that many insurance policies pay between 50% and 80% of the actual cost of your dental care.

- If you are paying with your insurance, we request that you deposit between 20% and 50% of the cost of care when you agree to treatment.
- Office visits, examinations and x-rays are payable in full on the day of the procedure if you are not paying with insurance. We take Visa, Mastercard, and Discover credit cards as well as a check or cash payment. If other arrangements are needed, please talk to the office staff.
- Co-pays and cash plans are due at the time of service.
- Special arrangements can be made, but must be agreed to **IN ADVANCE**. We will do everything possible to find a way to provide the dental care services you need.
- A fee of \$50 will be charged for cancellation without 24 hour notification or failure to show for a dental hygiene visit.
- A fee of \$75 per hour scheduled will be charged for cancellation without 24 hour notification or failure to show for appointments with the dentist.
- If I allow my account to become delinquent and it is referred to a collection agency, I am **SOLELY** responsible for any outstanding balances and all reasonable collection costs and attorney fees.

To avoid misunderstandings concerning payment, please indicate which method of payment you prefer:

_____ Cash, check, or credit card at time of service

_____ I will be utilizing insurance to cover part of the fee, and will pay 20% to 50% deposit. Any over-payment will be promptly refunded.

I understand I am financially responsible for all services rendered.

Patient Name: _____

Patient/Responsible Party Signature: _____ Date: _____