

Gresham Dental Group  
315 NW Burnside Rd  
Gresham, OR 97030  
503-666-5484

### Financial Policy Acknowledgement

I understand that I am financially responsible for charges and procedures not covered by my insurance, which includes deductibles. I understand that dental insurance is a contract between me and my insurance carrier. As a courtesy to me, Gresham Dental Group will bill my insurance company; however, regardless of the insurance coverage estimate, I am fully responsible for the fees associated with my dental treatment.

Payments are collected at time of service unless other arrangements have been made. If I have dental insurance, Gresham Dental Group will gladly assist in estimating the portion of the treatment covered by my insurance policy, and will collect the portion that is estimated to be my responsibility.

In addition to paying with check or cash, Gresham Dental Group also accepts Visa, Mastercard, Discover, AMEX, Care Credit and all flexible spending account cards. There will be a billing charge of 1.5% per month and an annual percentage rate of 18% on balances carried over 90 days with a minimum of \$.50

As a courtesy to our office, we ask for at least one business day notice for any changes that need to be made to an appointment. Without this notice, there may be a \$50 charge assessed to your account.

A \$25.00 charge will be added to your account for any check returned by your bank for any reason.

I hereby certify that I have read and understand the previous information. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

X

\_\_\_\_\_  
Please print name of patient

X

\_\_\_\_\_  
Please print name of patient/parent/guardian

X

\_\_\_\_\_  
Signature of patient/parent/guardian

X

\_\_\_\_\_  
Date