We are pleased that you have chosen our office to meet your dental needs. One goal is to provide the highest quality dentistry available, in a friendly, caring, family-oriented atmosphere. Our desire in serving you is not just treating your dental needs, but also building a relationship of Trust and Friendship. Our mission is to thoroughly communicate with you concerning every aspect of your dental visit. We want to answer any questions that you may have, whether it pertains to your treatment, insurance, or payment. We want you to be as informed as possible. We believe that dentistry is a partnership between the staff and the patient. If there is anything we can do to better serve you, please let us know.

The Staff of Dr. John Fogaros

Insurance Information

Our first task is to verify your insurance to determine what your coverage is (amount of deductible, percent that the insurance is estimated to pay, any limitations, etc.). This is not a promise of payment. Until your insurance is verified, services must be paid for at the time they are rendered. Once verified, you will be responsible for any deductible and co-payments at your appointment. In the event that your insurance company pays less than anticipated, you will be responsible for the amount at the time the insurance explanation of benefits is received.

Fee Agreement

Payment is expected when services are rendered. Those who have dental insurance are responsible for paying any deductible amount and any other amount not to be paid by insurance. Fees are computed on a cash basis. Unpaid balances will be subject to a late payment charge computed at the rate of 1½% per month or 18% per year with a minimum charge of $4.00 per month per account over 60 days. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

Authorization

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on the attached patient information sheet and medical history are correct to the best of my knowledge.

_____ _____

Signature of Responsible Party Date