

## PAUL V. GALLO, DDS

### FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance forms before seeing the doctor.

**FULL PAYMENT IS DUE AT TIME OF SERVICE.  
WE ACCEPT CASH, CHECKS or VISA/MASTERCARD.  
WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.**

#### Regarding Insurance

We may accept assignment of insurance benefits after your second visit. However, we do require **50%** of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance has not paid your account in full within **45** days, the balance will be automatically transferred to your credit card or the extended payment plan. A service charge of **1.5%** per month will be added to unpaid balances after **45** days. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.

All reasonable collection and/or legal costs required to collect fees due to Paul V. Gallo, DDS will be borne by the undersigned.

#### Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

#### Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, Mastercard, or payment by cash or check at time of service has been verified.

#### Missed Appointments

Unless canceled, at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

X \_\_\_\_\_  
Signature of Patient or Responsible Party

Date \_\_\_\_\_

X \_\_\_\_\_  
Signature of Co-Responsible Party

Date \_\_\_\_\_