Gulf Coast Endodontics
exceptional • gentle • root canal care

Frederick J. Grassin, DDS
Micro-Endodontic Specialist

www.gulfcoastendo.com
info@gulfcoastendo.com

FINANCIAL POLICY

Date:

Patient First Name: _____Last Name: _____

Address: _____
City State Zip

Please note that there are no "standard" fees for treatment. During your first visit we will discuss the probable number of visits, their length, and the fees involved. Endodontic fees vary case by case and are dependant upon the tooth and the complexity of treatment required.

For your convenience, we provide a number of payment options that may be used individually or combined according to your wishes. For your convenience we accept: Cash, Check, Money Order, or Credit Card: Visa, Master Card, Discover, or American Express.

Dental Insurance: Your dental plan is designed to share in your dental care costs. It will not cover the total cost of your treatment. Most plans cover between 20 to 80 percent of endodontic services. Sometimes, needed services are not covered at all. Generally, a dental benefit plan is a contract between your employer, or plan sponsor, and a third party (insurance company). These contracts vary widely. There are many ways in which dental plans are designed and how reimbursement levels are determined. It is your obligation to know how your dental plan is designed as well as its limitations. Your dental plan may not cover certain procedures that are required for the appropriate treatment of your unique situation. This does not mean these treatments are unnecessary. For most insurances, we will accept your estimated portion of the treatment fee and bill your dental insurance. In order to do this, we will estimate the portion your insurance is going to pay. Since this varies for each individual, usually 25-75% of the cost of the procedure is required at the time of service. Please keep in mind, however, insurance companies routinely indicate that coverage verification does not guarantee payment. If your insurance pays more than the estimated amount, a refund will be issued within 1 month from the date payment is received in this office. If your insurance pays less than the estimated amount, you will receive a statement from this office. We usually do not send monthly statements so prompt attention is greatly appreciated. NOTE: If your insurance company does not reimburse us after 2 submissions, you will be responsible for the remainder of the balance since we were unable to collect from them.

I, _____, accept full financial responsibility for the treatment performed in this office. I am aware that payment to the doctor is expected at the time services are rendered. I understand that finance charges will be added to unpaid balances. Additionally, I understand that in the event any unpaid balances are forwarded for collection I am responsible for any costs and/or fees.

Today, I plan to settle my fees with: (circle one) Cash / Check / Money Order / Credit Card / Other:_____

_____
Patient Full Name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority.

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phone (352) 596-3253 • fax (352) 596-2084