



Grayhawk Prosthodontics, P.C. Financial Policy

Thank you for choosing our office for your dental specialist needs. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we consider to be a very important part of your treatment. We require you to read and sign this document prior to any dental treatment completed.

Payment Arrangements:

Our office relies on reimbursement from our patients for the expenses incurred during their dental treatment. Payment in full at the time of service is expected, unless a written agreement is in place and signed prior to rendered treatment. Nonpayment, payment reversal, returned items or other default of these terms will result in bank, and/or collection fees assessed to your account. Any unpaid amounts remaining on your account after 30 days will result in a finance charge of 1.5% per month.

Regarding Insurance:

We will be happy to assist you in determining your dental insurance benefits based on the information you provide us. Our office is not contracted with any insurance companies. Your policy is a contract between you and your insurance company. Grayhawk Prosthodontics is not responsible for the accuracy of co-payments, deductibles, or other insurance benefits.

You are responsible for payment in full for services rendered. The assignment of benefits will be in your name, which means the insurance will issue any benefits available directly to you. Disputes in benefits will not be handled by our office.

Cancellation Policy:

We ask for at least **2 business days** advance notice for canceling or rescheduling an appointment; otherwise, a fee of \$50 may be assessed to your account. For scheduled appointments over 1 hour, a total of \$100 per hour will be assessed to your account.

Note: All cancellation fees must be paid prior to scheduling another appointment.

Thank you for understanding our Financial Policy. If you have any questions or concerns please bring them to our attention now as this will save any confusion or misunderstandings with regard to your account later.

I have read the Financial Policy and I understand and agree to the terms

Signature of Patient or Responsible Party

Date