

Financial Policy
Dr. Georganne McCandless

Payment is due at the time services are rendered. We accept cash, check, Master Card and Visa. Please be aware that the parent bringing the patient to our office is responsible for payment of all charges. If someone brings the patient to our office other than the parent, arrangements for payment should be planned accordingly.

Filing your insurance for the first visit will be your responsibility. We will provide you with the necessary information. We will file for subsequent appointments providing insurance verification has occurred prior to the appointment.

We are happy to accept insurance assignment. You must 1) Pay the **estimated** difference between what your insurance covers and the actual charges incurred. 2) After insurance pays, you are responsible for the balance in full upon receipt. 3) If insurance payment is not received from the insurance company within 5 weeks of submission, you will be expected to pay for all dental services rendered. In the event of a duplicate payment, you will be reimbursed by Georganne McCandless, DDS, PA. 4) **We attempt to provide the most accurate information available. However, insurance carriers will not guarantee their information so we regret that we can not be responsible for any discrepancies in benefits estimated. Information given to you by our office regarding your benefits is a courtesy; you should verify and be knowledgeable about your insurance benefits.** 5) Your insurance is a contract between you, your employer, and the insurance company. **We are not a party to that contract.** 6) If the recommended treatment involves some type of appliance, insurance assignment may not be accepted, and you will be expected to pay 50% when the impression of your child's teeth is taken, and the remaining balance is due the day the appliance is delivered.

I UNDERSTAND THIS FINANCIAL/INSURANCE ASSIGNMENT POLICY OF GEORGANNE MCCANDLESS, DDS, PA, AND HEREBY ASSIGN ALL MEDICAL/DENTAL BENEFITS TO WHICH I AM ENTITLED TO: GEORGANNE MCCANDLESS, DDS, PA. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THE ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT. **I AGREE AND ACCEPT THE ABOVE POLICY AND WILL ABIDE BY SUCH. ALL MY QUESTIONS REGARDING THIS POLICY HAVE BEEN ANSWERED.**

Signed _____ Date _____

The following information is needed for assignment to be considered:

Are you a new patient? Y/N

If you are not a new patient, please check one:

- The insurance information on file for my family has changed
 Pediatric dentistry has not previously filed claims for my family

Card holder name _____
Card holder DOB _____ SS# _____
Employer _____ Phone # _____