OFFICE FINANCIAL POLICY

Welcome to the office of Dr. Donald L. Goudy, Jr. Please read, initial each paragraph and sign the bottom of our office financial policy. This includes a waiver that we need in order to bill your insurance company. If you have any questions, please inquire at the front desk.

___ **Insurance Companies:** Our will be happy to bill it, provided that you have submitted complete and current information to us. Insurance companies now mandate a 90-day billing period. Therefore, we will not bill nor re-bill any insurance claims after 90 days should your insurance information be incorrect. All balances on your account will be due and payable immediately by you. If for any reason your insurance does not pay for your visit it is your responsibility to for service rendered.

___ **Secondary Coverage:** Our office will bill secondary insurance until the end of 2010. It will then become the responsibility of the patient to submit claims to the insurance carrier.

___ **Patient Portion:** All non-insurance covered procedures/patient portions are due and payable at the time of services rendered. Our office requires a credit card be kept on file in the case of non-payment by your insurance company.

___ **Treatment Plans:** Treatment plans are *estimates* of coverage and are not a guarantee of payment or eligibility. Previous charges from other offices can affect payment. The total fee is your responsibility. Once your insurance company has paid, if you have a credit, your credit card will be credited that amount. If you have a remaining balance, the remaining balance will be charged. If your insurance carrier has not paid within 60 days, the entire amount will be charged to your credit card.

___ **Cancellation policy:** We have a 48 hour cancellation policy. If you give less than 48 hour notice or do not show up for your scheduled appointment, you will be assessed a $75 fee.

___ **Contact information:** A current telephone, address and email are required at all times. The majority of office communication is through email.

My signature below indicates that I have read and understand the policies of this office and agree to comply with them.

I authorize Dr. Goudy to release to my insurance carrier and its' agents any information needed to determine the benefits payable under their coverage. I request that payment of authorized benefits be made to Dr. Goudy on my behalf for services rendered.

_____	_____	_____
Name	Signature	Date

OFFICE RETURN POLICY

___ **Returns do not apply:** On dental products.