GENE HASSELL D.D.S.
GENERAL & COSMETIC DENTISTRY
200 WEST MAIN STREET | PFLUGERVILLE, TX 78660
WWW.HASSELLDENTAL.COM
512.251.7503

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy. Payment is due at the time service is provided. We accept cash, personal checks, cashier's checks, money orders, Visa, Mastercard, Discover and Care Credit.

Insurance Policy:
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. As a courtesy to you we will help you process all your insurance claims. We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an estimate and that all charges you incurred are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for you that is provided by your employer, and the terms of your benefits are between you, your employer and your insurance company. Our office is not a party to those terms or agreements. We will cooperate fully with the regulations and requests of your insurance company in order to assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim.

Once insurance has paid their agreed benefits, a statement will be sent to you for any remaining balance, and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

On occasion, a grandparent or a single parent will be the responsible party and bring a child in for their dental treatment. Since it is our office policy to provide a treatment cost estimate before your scheduled appointment, please make arrangements for payment before dental treatment is rendered.

Cancellation & Late Policy:
Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We maintain a very busy schedule and must insist that appointment times be respected. If a cancellation is necessary, we require 24 hours advanced notice. An answering machine is available for messages left after business hours. Without a 24hr cancellation notice a fee will apply.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO GENE HASSELL DDS.

The undersigned hereby authorizes Dr. Hassell to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Hassell to make a through diagnosis of my dental needs. I also authorize Dr. Hassell to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk, I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance fee, rebilling fee, collection fee or attorney fee will be added to any overdue balance.

Patient (or responsible party)Signature _____ Date _____