Financial Policy

Hamid Namazi, DDS
3525 W. Dublin-Granville Rd.
Columbus, OH 43235

We at *Graceful Dentistry* are pleased you chose us to facilitate and care for your dental health needs. In order for us to keep costs as low as possible, we require that payment is made at time of service. The following is a statement of our financial policy, which we require you read and agree to prior to treatment.

Payment Options

- We accept Cash, Checks, master Card, Visa and Bank Debit cards.
- We offer extended Payment plans with no interest through third party financing with Cared Credit to those who qualify. Care Credit offers flexibility, and low payments for those who prefer low monthly payments
- Other financial arrangements are reserved for major work to be performed over $2,000. We will be happy to discuss these options with you if the situation applies.

Insurance

For those patients who have financial assistance from insurance, your estimated co-insuranc amount is due this time. We will continue to submit your claim for you; however, your insurance is a contract between you your employer, and the insurance company. As your dental provider our relationship is with you, not the insurance company.
All charges incurred are the responsibility of the patient regardless of your insurance coverage. We will cooperate fully with the regulations and requests of your insurance company that my assist in your claim being paid. Disputes or denied claims should be directed to your insurance carrier and/or employer.
Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received within 60 days from the date of filing, or your claim is denied, you will be responsible for paying the full amount at that time. If we receive any payment from your insurance company and you have paid your bill in full, we will remit the payment directly to you.

Emergency Patients

We require full payment for those seen for emergency appointment. We will file any insurance claims and reimbursement directed to you for this initial visit. Once established as a patient of record we will then only require you co-insurance at time of service.

Minors of Separated or Divorced Parents:

When two parents are each responsible for portions of a child's dental care, ***the Parent or Guardian who brings the child is responsible*** for co-insurance and full fee at date of service. They are also responsible for collecting payment from the other parent. Prearrangements must be made with our office if another party will be bringing the child for his appointment.

Returned Checks/ NSF

A $ 25.00 fee will be assessed for all returned or NSF checks. We reserve the right to reject check payments once a NSF occurs.

Short Notice Cancellations and Broken Appointments.

Each appointment is reserved time for you and only you. Each time appointments are not kept; other patients who do value their reserved time for treatment are penalized.
A $50.00 or more charge may be assessed for cancellations without a 48 hour notice or a missed appointment. We reserve the right to decline future appointments unless paid in full. We may also require your next visit be secured with a credit card deposit. This office and situation will determine when this should occur.

PLEASE TURN OVER FOR SIGNATURE PAGE

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I have read and understand the financial policies of Dr. Namazi and Graceful Dentistry. I understand I am responsible for all fees incurred for my dental treatment.

_____Patient initials

I understand insurance plans are payment assistance programs; they are not designed to cover the entire cost of treatment. I understand my insurance carrier may pay less than the actual bill for services. By signing this form I have authorize assignment of benefits directly to Dr. Namazi and this practice.

_____ Patient initials

I understand I am responsible for any and all charges that might occur if my account is turned over for collections.

_____ Patient initials

*Signed*_____ *Date:* ____/____/_____
Patient Signature

Parent
Or/ Guardian of: _____
Name of Minor