GALVIN & ROUND, P.C.
622 Hebron Avenue
Glastonbury, CT 06033

OUR FINANCIAL POLICY

Thank you for choosing Galvin & Round, P.C. as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AND DISCOVER

REGARDING INSURANCE

We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other dental insurance.

Regarding insurance plans where we are a participating provider – All copays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatments for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance our policy is to charge for missed appointments at the rate of $29 an appointment.

INTEREST & OVERDUE BALANCE

We reserve the right to charge interest in the amount of $1^{1/2\,\%}$ per month as provided by state law. If your account has an outstanding balance for more than 90 days, the account will be sent to an outside collection agency.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Please sign below acknowledging that you have read and agree to the Financial Policy.

X_____ Date_____
Signature of Patient or Responsible Party