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## **Financial Policy**

### **With Insurance**

We will gladly bill your dental insurance company for any charges incurred in our office. We do require those with insurance to provide us with sufficient information to bill your insurance company. Any benefit information we obtain from your insurance company is an estimate and only done as a courtesy. **Estimated benefits whether from our office verbally or from your insurance are NOT guarantees. Exclusions, limitations or unforeseen issues can cause patient responsibility to change.** You are ultimately responsible for any balance on your account. We require you to pay your estimated portion the day services are rendered. We will send you a statement or refund once the insurance has paid if there is any difference.

### **Self-Pay**

We ask that the services provided are paid in full by the time they are completed. If two visits are required 50% is due today and the remainder at the following visit.

### **Appointments**

Appointment times are reserved just for you. If you cannot keep your appointment, we ask you to give us 24 hours notice so that we will be able to fill your slot. We do reserve the right to charge a fee ranging from \$25-\$50, per missed appointment.

### **All patients please read and sign the following:**

I have read and understand the above policies. I authorize the release of any information to my insurance company pertaining to any services rendered. I also authorize payment to be made directly to the dentist. I am aware that any unpaid balance after work is completed is subject to a finance charge. Any collections fees for delinquent accounts are the responsibility of the patient.

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Patient Signature (or Parent if minor)

Date

### **For HIPAA Privacy Practices**

Please read the *Notice of Privacy Practice* sheet attached to the clipboard. Once read, please sign below. (You may refuse to sign this portion)

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Patient Signature (or Parent if minor)

Date