COMPLETE DENTAL CARE *of Naples*

Drs. Johnn & Diana Griffith

6360 Pine Ridge Rd. Suite 202

Naples, FL 34119 (239) 354-5353

Financial Policy / HIPAA

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, all major credit cards, as well as Apple, Google and Samsung Pay. We also accept outside patient financing, such as Care Credit. Please see the front desk if you have any questions regarding these payment options.

***Please Note**: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and / or legal assistance; you will be responsible for any collection and / or legal charges up to 35%.*

Do you have dental insurance?

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

As a courtesy to you, we will be happy to complete any dental claim forms for you to expedite your reimbursement. Please present your dental insurance card, or complete information, to the front desk if this is something you would like us to do for you.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our Office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy. ☺

Consent:

I have read, understand and agree to the above terms and conditions. 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 unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and / or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/ cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/ or from any such number, without reimbursement from us.

PRINT NAME _____

PATIENT SIGNATURE (*parent if minor*) _____

DATE _____