ENDRES GATEWAY DENTISTRY
"Oral Health is the Gateway to Healthy Living"

Financial Policy

Thank you for choosing Endres Gateway Dentistry, Inc. 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. Please understand that payment of your bill is considered part of your treatment.

When is my payment due?

If you do not have dental insurance, payment is due no later than at the time service is provided.

If you do have insurance, you must 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; the balance is due within 30 days of the date service is provided. If your insurance company has not made payment within 25 days after the date of service was provided, we may ask that you contact your insurance company to make sure payment is expected by the 30th day following service. If payment is not received from your insurance company, or if your claim is denied, you will be responsible for paying the full amount by the 30th day following the day we provided service to you.

How can I make a payment?

We accept many forms of payment including credit card, cash, and check. Returned or dishonored checks will be subject to a "returned check" fee of $50.00 which will be immediately due and payable. Outside financing is available upon request and approval.

☐ **Please check if you would like more information about financing options**

How does Endres Gateway Dentistry deal with insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

- All charges you incur are your responsibility regardless of your insurance coverage. 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. We are not a party to that contract.

- We are committed to providing the best treatment 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 determination of usual and customary rates.

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. Among other things, this form instructs your insurance company to make payment directly to us.

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

What happens if I do not comply with the terms of this financial policy?

If you fail to pay any amount when due, if any payment is returned, dishonored, or charged back by your financial institution, or you otherwise fail to comply with the terms of this financial policy, then you shall be liable for all expenses, including (without limitation) collection agency fees, attorneys' fees, and other litigation costs, relating in any way to the collection of any past due, dishonored, or charged back amount or your failure to comply with the terms of this financial policy.

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What if I have questions or concerns about my bill?

If you have a question or concern about any bill you receive from us, please contact us immediately so that we can discuss the issue. We find that we can resolve most issues quickly and easily. Regardless, before filing any claim or lawsuit related to any dispute over any amounts charged by us in any court, you must firstly notify us of your claim in writing by emailing officemanager@endresdentistry.com. Your notice must reference this financial policy, fully explain the basis of your claim, and state your proposed resolution. Within 30 days of receipt of your notice, we will schedule a meeting between you and us, and at that meeting you must, in good faith, attempt to resolve the claim with us. If no meeting is scheduled within the stated time, or if the claim is not resolved at the meeting, then you may proceed with filing your claim or lawsuit. You hereby agree to the exclusive jurisdiction and venue of the state and federal courts in Hamilton County, OH for the resolution of any claim or dispute arising out of this financial policy or the services you receive from us.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care of this financial policy.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO ENDRES GATEWAY DENTISTRY, INC.

Signature:_____ Date:_____
(Patient or Guardian)

Patient's Name:_____