Austin Endodontics, L.L.P. **Practice Limited to Endodontics**

Michael B. Doughty D.M.D., Erik J. Galian D.M.D., Robert R. Galvan Jr., D.D.S., Deepika L. Ganne, D.D.S.

Financial & Insurance Policy

Thank you for visiting our office. Claims are filed on behalf of our patients for dental services performed in the office to the primary insurance company. Secondary insurance is the patient's responsibility. As a courtesy to you, we will gladly process your insurance. However, if this claim is not paid within 30 days, the balance is your responsibility. To assist in filing your secondary claim, obtain a complete statement of services from our office. The benefits belong to you, and it is up to you to ensure that you are receiving appropriate reimbursement under the terms of your plan. There is NO GUARANTEE of benefits from the insurance company until a claim is received and processed by the insurance company. Therefore, benefits quoted to you are only an estimate provided by the insurance representative. An 18% APR finance charge will be assessed on all accounts 30 days past due. Root canal therapy fees can range from $800 to $1800 excluding x-rays.

Payment is due at the time of service for all procedures. If you have dental insurance, your estimated portion is due at the time treatment is started. ***Examinations Only* are 138.00 and are due at the time of service.** It is our office policy that patients pay for exams in full and we will then file a claim for the insurance company to reimburse you. For your convenience, we accept checks, cash, Visa, Master Card, Discover and American Express. Please feel free to discuss any financial concerns you may have prior to being seen by the doctor. Regarding appointments, a 24 hour notice is required for cancellation. A $100 missed appointment fee will be charged if 24 hour notice is not given. Thank you for your consideration.

Please provide the following insurance information.

Policyholder___________________________ SS# or ID#_________________DOB ___/___/__

Employer __________________________________ Phone (_____)___________________

Patient Name___________________________ DOB _______/________/______

Insurance Company _________________ Phone (_____)__________Group# __________

Eff.__/__/__ Ins Address_____________________ City_____________ ST____ ZIP_____

I hereby authorize payment of dental benefits directly to the provider of services and certify that I will be responsible for payment in full for all charges incurred from treatment rendered by this office.

____ Date ________________________

Signature

For Office Use Only

Estimated Treatment ______________________ Deductible _____ met___/ ________%

Estimated Patient _________________________ Yearly Max. ________ used _______

Estimated Insurance ________________________ Ins Rep _________________________

Discount_________________________________ Waiting period for Endo? Y N