MARC P. GIMBEL, D.M.D., L.L.C.

Diplomate, American Board of Endodontics

PRACTICE LIMITED TO ENDODONTICS

Dear Patient,

Welcome to our office. We will do our best to make your endodontic therapy as pleasant and comfortable as possible, while promising you the highest quality treatment attainable.

In an effort to provide you with quality Dental Care and flexible payment arrangements, we feel it would be helpful for you to have knowledge of our fee schedule. This, we hope, will avoid any misunderstanding. Please ask if you have any questions about our fees, financial policy, or your responsibility. **Please note that the fees listed may be increased by $100-$400 due to complications that may arise such as re-treatments, going through crowns and bridges, posts, calcified canals/additional canals, apicoectomies, etc…**

Root Canal Therapy:

Anteriors	**$1495**	**Consultation & Diagnostic Tests**	**$259**
Bicuspids	**$1695**	**CBCT Scan**	**$245**
Molars	**$1795**	**Nitrous Oxide**	**$200/per visit**
Re-Treatments	**$1595-$1995**	**Non-Office Hrs/Weekends/Holiday**	**$500 + treatment**
Apicoectomies	**$1595-$1995**	**Personal Protective Equipment**	**$10/per visit**

Payment in full is expected before the completion of treatment.. For the convenience of our patients with dental insurance, we will be happy to complete and submit your insurance form one time **as a courtesy to you;** however, if the insurance company is not one with which our office participates, payment in full is expected before completion of treatment. **The insurance plans we participate with are: Ameritas/Principal, Delta Dental Premier, and Signature Wellness.** There will be a $10 surcharge for each additional submission. Returned checks will be subject to a $35 charge per occurrence.*

We now offer the following payment options:

_____Cash _____Care Credit (please see receptionist for information)

_____Check _____Visa/MasterCard/Discover/AMEX

SIGNATURE: _____ **Date:**_____

Patient or authorized guardian

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE Marc P. Gimbel, D.M.D., LLC to provide any insurance company(s), claim administrator(s) and consulting health care professionals' information concerning health care, advice, treatment or supplies provided.

SIGNATURE: _____ **Date:**_____

Patient or authorized guardian

PLEASE TURN SHEET OVER TO COMPLETE FORM

ALL APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE WILL BE SUBJECT TO A $150.00 MISSED APPOINTMENT FEE.

***A service charge of 1.5% per month will be applied to all past due accounts over 60 days. In the case of default of my account, I agree to pay collection costs, and interest on the unpaid balance until paid in full. There will be an additional 33 % charge on balance owed for attorney's fees in attempting to collect on my present and future account balance.**

Please sign where indicated on the front and back of this page; then return to the receptionist before your visit. Thank you.

OUR FINANCIAL POLICY CONTINUED

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.
If you have an insurance plan that our practice participates with, you are responsible an estimated co-insurance based on the information we are able to access from your plan. Your insurance will cover a percentage of your bill and you are responsible for the balance within 60 days from the start of service.

The insurance companies that Marc P Gimbel, D.M.D.,LLC participates with are listed on the other side of this form. We are not a party to this contract in most cases. We will inform you if we are a party to your company. It is your responsibility to check with your insurance company on your dental coverage. We will file insurance claims as a **courtesy to our patients; however all charges are ultimately the patient's responsibility.** We will wait a MAXIMUM of 45 days for your insurance company to respond with a payment, denial or no response. After that complete payment is the patient's responsibility. I agree to make payment as stated above; regardless of the fee my insurance may or may not cover.

SIGNATURE: _____ **DATE**:_____

Any remaining account balances with or without insurance coverage will be subject to a finance charge of 1.5% per month with a minimum finance charge of $.50 per month. Balances older than 60 days (after insurance company payment, denial, no response or two billings) will be forwarded to collections with a collection agency. All accounts sent to collections will incur a collection charge. Accounts requiring the services of a lawyer will have an additional 33% charge on the balance owed in addition to all associated legal fees added to the balance.

SIGNATURE: _____ **DATE**:_____

X-Ray Policy

1) If x-rays need to be forwarded to another doctor or insurance company, they will be done at no charge to the patient. They can be duplicated and sent as soon as possible, as long as we have the address and phone number of the doctor or Insurance Company.

2) If patients wish to pick up the x-ray duplicate films and records or have them sent to themselves:

   a. They must pay at least a $25 fee.
   b. They must submit their request for copies in writing.
   c. Any unpaid portion of the diagnostic section of their bill must be paid in full.
   d. We will forward the records a full 14 days after we receive all of the above.
   e. There are no exceptions as this is a state law and dictated by the State Board of Dentistry.

SIGNATURE: _____ **DATE**:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have read a copy of this office's Notice of Privacy Practices.

PRINT NAME: _____

SIGNATURE: _____ **Date:** _____

For Office Use Only We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)