Laura Gramse, R.D.H.,D.M.D.
2194 Wilbraham Road
Springfield, MA 01129

FINANCIAL AGREEMENT

Methods of Payment

1. Cash, Check or Credit Card (MasterCard, Visa)
2. Dental Insurance (Described Below)
3. Care Credit (application available) or any other 3rd Party Financing

Dental Insurance

1. We are pleased you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company. **We will need you to bring us a copy of your benefit booklet if you would like help interpreting your benefits.**

2. As a courtesy to you, we will file your insurance and accept assignment of benefits. **We ask that your estimated co-payment be paid at the time of service.**

______I am authorizing my insurance company to make payments directly to Dr. Laura Gramse.

______I choose not to assign benefits and will pay for my treatment at the time of service.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.

RELATED INFORMATION

1. Returned checks will be subject to a $25.00 fee.
2. Account balances older than 30 days will be subject to a $10.00 per month billing fee and 1.5% interest charge.
3. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e. attorney fees, court costs, and collection agency fees).
4. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. 24 hours notice is needed to avoid a $25.00 charge.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

NAME____
(Please print)

SIGNATURE:____ **DATE:**______________