Financial Policy

Charges for professional services are due at the time dental treatment is provided. We make every effort possible to provide you with preventive, corrective and cosmetic dental treatment that fits your timetable, is affordable and does not compromise in the quality of care or materials prescribed by the doctor.

Professional services that are rendered to you are fully your financial responsibility regardless of insurance coverage. If you carry dental insurance, it will be your responsibility to pay your co-payment and deductible at the time dental services are rendered. Our office will bill your insurance company as a "courtesy" and if the insurance company has not paid within 60 days of the charge, the full balance will be due immediately.

Our scheduling coordinator will offer you appointment options for your dental needs. Some treatment may require several visits and pre-planning. Once these visits are scheduled, at least 48 hours notice is required in the event you need to change an appointment in order to avoid a rescheduling fee ($150). This gives us the opportunity to offer your appointment time to a patient in need (dental emergencies, etc.) We appreciate this courtesy because that emergency patient waiting to schedule could be you in the future. Please ask us about our priority call list for appointment availability.

Dental Insurance

Your insurance can be a helpful supplement towards your dental investment depending on your plan's benefit options. Be assured that we will use all necessary resources to ensure that you receive the maximum benefit under your particular plan.

Patients who have dental insurance should be aware that we are happy to submit your insurance claims to your carrier with the information you supply to us for compliance with your insurance benefits. If you carry PPO dental insurance, you will be responsible for your estimated co-payment amount at the time of dental treatment. The estimated portion your insurance company may pay is just an "estimate" and we cannot guarantee what, if any, your insurance covers towards your dental treatment. Any portion not covered by dental insurance is the responsibility of the patient.

I understand that I am responsible for any collection fees (may be 35% or greater) or legal fees which may be incurred as a result of my failure to pay for my dental services. _____

I authorize release of information to my insurance company and assign insurance benefits payable to Dr. Greg Ceyhan DDS., PLLC. _____

I acknowledge that I have read and received a copy of the office's "Notice of Privacy Practices" by initialing here: _____

I further understand that Dr. Greg Ceyhan DDS., PLLC requires a 48 hour cancellation notice. I agree to pay in full the rescheduling fee for all missed or failed appointments._____

I agree to pay a $35 fee for all returned or NSF checks.______

I grant the dental office to contact me through e-mail to remind me of any upcoming appointments at the e-mail provided. ______

Consent to Treatment

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient or Guardian Signature: ____

Patient Name (Print):____

Date: ______________________________