GKG Gina K. Garner DDS, PC

EXCELLENCE IN DENTISTRY

Welcome and thank you for choosing Gina K. Garner, DDS, PC for your dental care. We are committed to providing you with the highest quality dental care.If you have any questions for our helpful and knowledgable team, please don't hesitate to ask!

Primary Insurance Information

Insured Name:_____ Insured Date of Birth___/___/_____

Insured SSN or Member ID#:_____ Employer:_____

Employer Address:_____ City, State, Zip:_____

Employer Phone Number:_____ Insurance Company:_____

Insurance Company Address:_____ City, State, Zip:_____

Insurance Phone Number:_____ Group Number:_____

Relationship to Insured: Self_____ Spouse____ Child____ Other____

Secondary Insurance Information

Insured Name:_____ Insured Date of Birth___/___/_____

Insured SSN or Member ID#:_____ Employer:_____

Employer Address:_____ City, State, Zip:_____

Employer Phone Number:_____ Insurance Company:_____

Insurance Company Address:_____ City, State, Zip:_____

Insurance Phone Number:_____ Group Number:_____

Relationship to Insured: Self_____ Spouse____ Child____ Other____

Initial_____ **Insurance.** The patient is responsible for knowing their insurance benefit. As a courtesy, our office will verify your benefits prior to your appointment. This is not a guarantee of benefits coverage. We provide an estimate of insurance co-pays for provider services. However, any proposed treatment plan and fees are only an estimation and are not a guarantee of payment by your insurance company. We will gladly file your insurance claim on your behalf. We allow 45 days from the date a claim is filed for the insurance company to pay. If the insurance carrier does NOT pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. - deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc. other than to supply factual information when necessary. If your claim is processed differently than you expected, it is your responsibility to follow up with your insurance company directly. You are responsible for the timely payment of your account.

Initial_____ **Non-Covered Services.** An "Insurance Waiver" may be required to acknowledge understanding of your responsibility for paying non-covered services. In dentistry, there are many procedures that are considered by private insurers as non-covered, including, but not limited to temporomandibular joint (TMJ) disorder treatment, occlusal night guards for bruxism, composite resin fillings, composite resin bonding, and all porcelain crown restorations, to name only a few. If you are coming in for a non-covered service, please be prepared to pay for the service in full. Cosmetic procedures including, but not limited to porcelain veneers, all porcelain crown restorations, and cosmetic resin bonding may not be covered by insurance and claims will not be filed for them. A deposit of $150 will be required to secure your cosmetic appointment. The deposit will be applied to your treatment cost, but will be forfeited if you NO SHOW or cancel less than 24 hours prior to your appointment.

Initial_____ **Minors.** The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have a written authorization for medical treatment signed by the parent or guardian before treatment can be rendered.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement. I understand I will be financially responsible for all charges.

Patient Name _____ DOB _____

Responsible Party Signature _____ Date _____