

**MARK R GADBERRY, DDS INC**

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### **PATIENT FINANCIAL PROTOCOL**

This statement is to inform you of our financial protocol. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial protocol is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. In order for our office to file your insurance claim you must:

- Provide us with current information relative to your claim, including insurance card, ID number, employer, birth date, address, and social security number. This information is requested on the Patient Registration form, which we ask that you complete during your initial or subsequent visit.
- Pay your co-pay or deductible at the time of service.
- Pay for services not covered by your insurance carrier.

**Payment is due at the time service is provided.** Our office accepts cash, personal checks, MasterCard, Visa, Discover and American Express. We also offer flexible monthly payments and same as cash options (upon qualification). A \$25 fee will be charged for all returned checks and balances older than 60 days may be subject to finance charges at the rate of 1.5% per month (18% annually).

If you have any questions regarding your insurance or our financial protocol, please ask. We want to make your visit productive and enjoyable and we are committed to providing you the most positive experience in dental care.

*I have read and fully understand my responsibilities under this protocol.*

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**PRINT PATIENT NAME**

\_\_\_\_\_  
**PATIENT/GUARANTOR SIGNATURE**

\_\_\_\_\_  
**DATE SIGNED**