Gold Hill Family Dentistry
Dr. Casey Clingan
492 Second Ave.
Gold Hill, OR 97525

Financial Policy

Thank you for choosing Gold Hill Family Dentistry LLC as your dental provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of your Financial Policy, which we require you to read and sign prior to any treatment.

Payment for services is due at the time services are rendered, including any dental insurance deductible and/or estimated portion unless prior arrangement have been made, as we do not offer payments. We accept cash, check, Discover, Visa & MasterCard, American Express & Care Credit.

If you have dental insurance, we will be happy to process your insurance claim for you. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges not paid by your insurance carrier are your responsibility.

We will make every effort to contact your insurance company at your appointment to determine what your estimated co-pay will be. This will be done on your first visit only. If it cannot be determined, we will require 20% to 50% of our fee to be paid when treatment is rendered depending on the type of service. When the insurance payment is received, if there is a credit, a refund will be sent to you promptly. If there is an additional amount due, we will send a statement for the balance that will then be immediately payable in full. It is the responsibility of the patient, not the provider to know what is covered and what is excluded from his/her plan.

I accept full financial responsibility for all charges whether or not they are covered by insurance.

I hereby authorize payment to Gold Hill Family Dentistry LLC of the group insurance benefits otherwise payable to me. I also authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. If it becomes necessary to employ collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all cost and expenses including reasonable attorney fees.

I hereby authorize Dr. Casey Clingan to administer any treatment and to administer such x-rays, anesthetics, and dental procedures as may be deemed necessary or advisable in diagnosis and treatment of any dental conditions that Dr. Clingan discusses with me. I understand treatment and the use of anesthetic agents embodies a certain risk.

This office is NOT a party to your general judgment (divorce decree). The accompanying adult is solely responsible for full payment regardless of what your general judgment may state. Any minor child must be accompanied by a parent or legal guardian.

We reserve the right to apply a finance charge/billing charge in the amount of 1.5% per month or 18% annually or a $5.00 billing charge to all balances after 90 days as allowed by state law. A fee of $25.00 will be assessed to your account for any check returned unpaid by our bank.

AUTHORIZATION

I authorize the release of medical and dental information including photographs to insurance carriers and to other health care providers involved in the care of this patient. These records may be used by Dr. Clingan for teaching purposes, scientific publication, social media, advertising and credit bureau reports as necessary. In the future, please advise Dr. Clingan of any changes in your medical or dental health while under the care of our office. Cell phone and carrier information is used to confirm appointments. Thank you.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

Signature: Date: