Financial & Cancellation Guidelines

Thank you for choosing our office as the home for your children and family. We are committed to providing you and your family with the highest quality dental care.

Payment is due at the time of service. Our office accepts cash, personal checks, Mastercard, Visa, American Express and Discover. Outside financing is available upon request and approval.

Treatment recommended is based on your child's needs, not on insurance coverage.

For those patients who are covered by insurance, we will be happy to bill on your behalf. Verification of benefits is not a guarantee of coverage.

We will collect any co-payments, deductibles, or payment at the end of your visit and submit an insurance claim on your behalf. In most cases, we will accept assignment of benefit from your insurance provider. If we are unable to accept assignment of benefits on your behalf, the reimbursement check will be mailed directly to you. In the instance that assignment of benefit is not possible, payment in full is due at the time of procedure. Any outstanding balance that is your responsibility will be expected to be paid in full within 30 days from notification.

I understand that Dr. Gruenbaum and her team cannot guarantee any reimbursement from the insurance company. I will assume responsibility of notifying this office of any changes in insurance coverage.

I authorize the office of Dr. Gruenbaum to release to any company providing me with dental insurance any information, including the diagnosis and the records of all treatments and/or examinations provided to us by Dr. Gruenbaum, DDS, LLC, for the purpose of billing.

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. By signing this form I am consenting to allow Dr. Gruenbaum to use and disclose my protective health information to any credit card, bank, financing company or insurance company when they request such information to process an account and assist with payment.

Please Note: Returned checks will be subjected to an additional fee of $40. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges.

I agree to this financial policy. I have read and received a copy of this document (if requested). I authorize my insurance company (if applicable) to pay my dental benefits directly to my dental office.

Patient Name: _____

Patient Signature: _____ Date: _____