Written Financial Policy

Thank you for choosing Graves Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy for our patients to manage as possible by offering several payment options.

Payment Options:

We accept:

- Cash, Check, all major credit cards
- Monthly payment plans from CareCredit

Please note:
Graves Family Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Dental Insurance:

For patients with dental insurance, we are happy to work with your carrier to utilize your benefits and directly bill them for reimbursement of their estimated portion of your treatment, and we take great care to maximize the accuracy of these estimates. Please note, however, that you are personally responsible for payment of all dental services regardless of insurance coverage. Neither our submission of bills to your insurer nor the providing of estimated costs shall be considered as agreement on the part of Graves Family Dentistry to accept insurance payment as complete satisfaction of your obligation to pay for services rendered to you or your family members.

It is your responsibility to be sure that Graves Family Dentistry has correct, up-to-date insurance information. If this information is not made available to Graves Family Dentistry, no insurance company will be billed.

By my signature I acknowledge my understanding of these policies and agree to be personally responsible for payment of any unpaid balance for dental services, regardless of whether those services and/or procedures are covered by my dental insurance plan.

Patient/Guardian Name (*Print*) Signature Date

Primary Insurance Information

Name of Insured: _____
Last First MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐Child ☐Other _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip

Insured's Employer: _____

Employer's Address: _____
Street City State Zip

Ins Plan Name: _____

Ins Plan Address: _____
Street City State Zip

Secondary Insurance Information (if dual insured)

Name of Insured: _____
Last First MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐Child ☐Other _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip

Insured's Employer: _____

Employer's Address: _____
Street City State Zip

Ins Plan Name: _____

Ins Plan Address: _____
Street City State Zip