

GREGORY V. KEATING, D.M.D.
General Dentistry

Dear Patient

We would like to take this opportunity to express our appreciation for your support and patronage. Our goal is to provide you with quality care at a reasonable fee. In order to serve you better, we have instituted the following policies to allow our staff to concentrate more fully on patient care.

At the time of service payment is due in full. If insurance is utilized, the estimated amount that is the patients' responsibility is due in full.

All accounts are past due after 90 days and will be assessed a service charge of 1.5% per month. Additionally, all past due accounts are subject to collection to include all collection costs and/or attorney fees.

A minimum of 24 hours notice is required for appointment cancellations or changes to avoid a broken appointment charge of \$10.00 per 15 minutes. Confirmations calls are done as a courtesy only. You are still responsible for your appointments.

I agree to the above policies and I give permission to process and release necessary insurance information to include the assignment of benefits to my dental office. I have received the pamphlet entitled Dental Insurance. I understand that it is my responsibility to call my insurance company if I have any questions concerning my benefits prior to my appointment.

NAME _____

SIGNATURE _____ DATE _____