



TAIRA DENTISTRY

Gregg S. Taira, D.D.S.

Janine A. Taira, D.D.S.

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Office Financial/Insurance/Privacy Policy

Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when you pay for our services at the end of each visit. Our front desk staff can provide you with the approximate fee for treatment before your appointment upon request. Please do not hesitate to ask for an estimate. To make payments convenient for you, we accept **cash, personal and business checks, Visa, MasterCard, and Discover.**

Dental Insurance

We are **out-of-network** for ALL managed care/network insurance plans. Insured patients should read their policies carefully to become familiar with its benefits and limitations. It is important that you understand that insurance is usually designed to reduce your cost, not eliminate it completely. Benefits and limitations vary widely between different insurance carriers and employers. As a new patient, you are responsible for the total cost of your first visit regardless of your insurance coverage. Insurance will be submitted as a courtesy to you, and we will reimburse you for any insurance payments due to you. Secondary insurance submission is your responsibility. We will assist you by providing copies of history and/or past claims. Please remember your insurance disclaimer states that benefit information is not a guarantee of payment. Thus, you are responsible for the full charges regardless of the actual insurance payment, maximum benefit allowances reached, and time limitations.

Your Financial Responsibility

If your account is outstanding for more than 45 days, a monthly service charge of 1.5% (18% APR) will be added to the balance. If the account is not cleared within the time specified, the account will be turned over to our collection service and you will be responsible for a \$30 collection fee, plus attorney's fees and court costs. A billing fee of 5% per statement may also be charged after the initial billing period.

Failed appointments will be subject to a missed appointment fee unless canceled at least 24 hours in advance. This will be charged at a rate of \$50.00 for each hour of time block scheduled.

Returned checks are subject to an additional fee of \$35.00. Immediate remittance in the form of cash, money order, or certified funds is required.

I have read the above policy and agree to accept financial responsibility.

I authorize the release of any information necessary to process my claim.

I will assign insurance benefits directly to Dr. Gregg Taira, if allowed.

I have read the office **HIPAA policy** and may request a copy.

Name: _____

Signature acceptance: _____ Date: _____