**GARY J. WESTERMAN, DMD**
1063 Main Street North • Southbury, CT 06488
(203) 264-5630

# *Welcome to our office!*

## OUR FINANCIAL MENU

**FORMS OF PAYMENT:**
To facilitate what we believe is your right to the best dental care available, you may choose from any of the following (including any combination thereof): cash, personal check, Mastercard, Visa, or extended payments with our health care card (ask for details). Balances over 60 days may incur a finance charge of 18% APR.

**REGARDING PRIVATE INSURANCE PLANS:**
Your insurance is a method for you to receive reimbursement for a percentage of your dental treatment. The range of benefits for a given procedure may be from 0-100%, depending solely on what your employer wishes to offer his/her employees. In addition, some plans base their mount of benefit on a schedule of fees arbitrarily determined by the insurance companies. For a given procedure, therefore, you may receive a lower percentage of our actual fee than the reimbursement level indicated in your dental plan.

We will be happy to assist you in completing and submitting your claim forms. We ask for all estimated co-payments at the time of treatment.

The financial obligation for dental treatment is between you and our office; the insurance company is responsible to you, and not to our office. Once your carrier has paid the claim, any difference will be due upon receipt of the statement. If for any reason we have not received your insurance carrier's payment within 90 days after the claim, the remaining balance will be due and payable by you at once and subject to 18% APR.

**APPOINTMENTS:**
Appointment Times are reserved especially for you. Kindly give at least 24 hours notice if changes must be made. There may be a fee charged if an appointment is missed without proper notice.

## ASSIGNMENT OF BENEFITS

*Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.*

**I authorize release of all information which is necessary to process my insurance claims and pertinent to my dental care. I assign all dental benefits to which I am entitled to Dr. Westerman. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as value as the original.**

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.**

**Patient**_____ **Date**_____

(Parent/Guardian if minor)

# GARY J. WESTERMAN, DMD

I understand that my appointment times have been reserved specifically for me. If I must cancel or change my appointment, I will give at least 24 hours notice. I further understand that if I miss any appointments without giving 24 hours notice, or arrive excessively late, additional appointments will not be given.

**Patient X** _____ **Date** _____
(Parent/Guardian if minor)