G. Michael Maitre, D.M.D., PA
801 University Blvd., Suite A1
Mobile, AL 36609
251-344-4571

Patient Agreement / Authorization Form

Patient _____

PAYMENT POLICY

Our policy is to require payment at the time services are provided. For your convenience, we accept cash, Visa, MasterCard, and your personal check. We also accept certain insurance plans upon verification of benefits and coverage; Claims are filed on such plans as a convenience to our patients; it is your responsibility to pay deductibles, co-pays, and non-covered amounts at the time of your office visit.

We attempt to remain informed about our patients insurance plans; however, due to the enormous number of such plans, it is impossible for us to determine the exact benefits which each individual plan might pay; therefore, we rely on you to be knowledgeable about your insurance plan and the coverage and benefits it provides. ***Please note: By filing a claim on your insurance, we do not guarantee the insurance coverage or benefits paid, nor can we accept responsibility for any amounts which your insurance company may not pay. Written or verbal estimates given by our office are not a guarantee of payment. Amounts filed on your insurance are your responsibility; if for any reason a claim is not fully paid by your insurance, the remaining unpaid balance will become due from you, and payable at that time.*** Generally we allow 45 days for claims to be paid by your insurance company.

Our fees are considered standard with other general dentist in the Mobile area. In giving you the care that you need and deserve, we do attempt to keep your cost to a minimum. Emergencies and insurance reimbursement are handled on an individual basis: please feel free to discuss financial matters with the office manager.

I have read and understand the payment policy above, and agree to comply accordingly. I further understand that, in the event an attorney is employed to collect sums due for services rendered, G. Michael Maitre D.M.D., PA is entitled to a reasonable attorney's fee.

Signature_____Date_____
(party responsible for payment)

Assignment Of Benefits
I authorize any payment due on my claim to be made directly to G. Michael Maitre D.M.D., PA

Signature_____Date_____