Gabet Family Dentistry

Charles F. Gabet, D.D.S.
Galen R. Williams, D.D.S.
901 N. Williams Street
Angola, In 46703
260-665-3637
Fax- 260-665-6142

Disclosure agreement:
Date: _____

Full Name_____

Reason for visit:
_____Routine preventive
_____I have a specific problem that I would like evaluated.
My chief complaint is_____

_____ .My insurance plan covers Preventive Dental Service
_____. My insurance plan does NOT cover Preventive Dental Service
_____. I do not know if my insurance plan covers Preventive Dental Service.
My dental insurance deductible is, _____and will be paid in full at the time of service.

I agree to pay for any and all dental services I receive from Gabet Family Dentistry that my insurance company refuses to pay, for whatever reason. This office will file a dental claim on my behalf. However, if my insurance company denies payment for any reason I will pay upon written/verbal notice of their refusal. Failure to pay within 45 days of filing, with respect to this agreement, is considered a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visits with a diagnosis that was encountered and documented in my dental record. To ask this office to change a diagnosis solely for the purpose of securing a reimbursement from an insurance carrier is inappropriate and fraudulent.

In the event that I do not pay for services when they are due, I agree to pay all costs of collection, including reasonable attorney fees, whether or not a lawsuit commences as part of the collection process.

Signature_____(provided by responsible party if patient is a minor)
Witness_____