Glauser Family Dentistry
12401 Hymeadow, Bldg 5 Austin, TX 78750
(512) 250-8225

We are dedicated to providing you and your family with quality, personalized dental care. We appreciate that you have chosen us to assist you with your dental health and want to provide you with the best experience possible.

PLEASE INITIAL EACH STATEMENT AND SIGN BELOW:

____ Your appointment time is reserved exclusively for you so that we can respect your time here in our office. We will provide reminders from our office as a courtesy to you, but if you are unable to keep your scheduled appointment, **kindly call our office to provide 48-hour notice.** Calling the office directly gives us the opportunity to reschedule you so that your care is not unduly delayed. Your notice also allows us to help another patient with his/her dental care. **Failure to contact us as requested or a late appointment change may result in a $50 Fee.** We do understand that emergency situations happen and will work with you if this is the case.

____ As a courtesy, we file your treatment with your insurance company. We will work to obtain the maximum amount allowed under your plan. We rely on you to provide us with your correct and current insurance information. We do our best to estimate your patient portion, but cannot always predict the many quirky exceptions that insurance companies are adding every day. Now that insurance companies have slowed their payments to providers, we request that you pay for any deductible or uncovered portion at the time service is rendered. **In the event your insurance denies payment of service or has not paid within 60 days, you are responsible for the account balance**.

____ **The patient portion is due at the time of service** unless prior financial arrangements have been made (See optional below) We accept Amex, MasterCard, Visa and Discover as well as cash and personal checks. We offer third party financing thru Care Credit. It seldom occurs, but if your account is not paid within 90 days of the date of service and no financial arrangements have been made, we need to let you know that you will be responsible for any legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

OPTIONAL:

- For those patients that have an H.S.A account and/or patients that would like to wait for insurance to pay, we MUST have a card on file. You will receive a courtesy call (message will be left) before the card is run, after insurance has paid their portion.

Name:____ Zip:________________

Credit Card #____ Exp: ___________

____ **For appointments that extend an hour and a half or more we may ask you to reserve your appointment with a %50 deposit that will apply towards the out of pocket expenses for your services. If the appointment is canceled or moved with-out our 48hr notice $75 will be deducted from the deposit.**

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Signature of Patient or Responsible Party Date