Gordon R. Ediger, DDS

Parkway Plaza Dental
13450 Roe Avenue
Leawood, KS

Financial Policy and Consent for Services at Parkway Plaza Dental
Dr. Gordon R. Ediger & Associates

We would like to thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our financial policy and consent for services.

Patients with Insurance:
Please have your correct insurance card available for us to photocopy so we will be able to confirm your dental benefit coverage. We will provide you with an estimate for your co-payment amount and expect that estimated portion to be paid today. Any delay in obtaining sufficient information may result in consultation and/or treatment to be rescheduled. If we cannot confirm your dental benefits, we will ask for full payment. Once provided with the correct information, we can then file the insurance for your reimbursement. We would be happy to complete your insurance form in an acceptable way that receives the best return for you. However, this does not absolve the patient of the full responsibility for the charges. The estimate provided by our office is to be considered as a guideline only until the final insurance payment is received and your account reconciled.

Patients without Insurance:
If you currently do not have insurance, we can provide you with an estimate of the charges prior to our initial consultation by the doctor. The estimate may vary depending upon the final diagnosis and type of treatment rendered. The full balance is expected to be paid at time of service.

Financing is available for extensive dental treatment to those who qualify. We will be happy to consult with you on this method of payment. In the event a legal suit or should outside collections become necessary to enforce payment of the account, the patient agrees to pay for all collection fees and/or attorney's fees in addition to court cost as may be deemed reasonable.

To accommodate you, we accept the following methods of payment: Cash, Check, Master Card, Visa, Discover, American Express, Care Credit, and Capital One.

Consent of Services
There is no assurance of success that has been or can be given in dental treatment. There is always the possibility that further treatment may be necessary which may result in additional charges. In signing below you acknowledge full responsibility for the payment of all necessary services on the date treatment is started. A six-month warranty clause is included with all dental procedures and a 2-year replacement warranty with preventive sealants.

I understand that specific amount of time is allotted for my visit each time I schedule and the terms for cancellation have been explained to me. I understand if I need to cancel my appointment, I need to inform the office with 24-hour notice.

I have read, understood, and agree to the above financial policy and consent of services.

_____ Date: _____
Signature of Patient and/or Responsible Party