Welcome to the office of Dr. Gregory Jann

Office Financial Policy

We believe in the importance of quality dental care and we strive to provide the best dental treatment possible. We understand the financial limitations that can influence your choice of care as well. For this reason we want to assure you of our flexible approach to financing.

We have a private practice which requires that we collect payment in full at the time your dental service is rendered. We accept MasterCard, Visa, and Discover, cash, personal checks as well as Care Credit (Health Finance Plan with a six month maximum requirement). Returned checks will result in a $35 fee in addition to the balance. This will require the balance to be resolved with cash or a credit card.

Insured Dental Patients

We work with most insurance companies and try to maximize your dental coverage through meticulous detailing of procedures and interaction with your insurer. We will file your primary dental claim insurance form to your current insurance company on file. Up to date and accurate insurance information will prevent refiling charge to you.

Primary Insurance information

Insured's name_____Social Security#_____

Insurance company _____Phone _____

Address_____

Union or Local # _____Group_____

Employer Name _____ Phone #_____

Insurance agreement

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy including benefits, limitations and exclusions. I understand that filing of claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement. I understand that any outstanding balance on my account will be due within 45 days of procedure to Dr. Jann by me.

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Signature of responsible party Date