George Harouni DDS

Thank you for choosing George Harouni, DDS as your dental provider. It is our goal to provide the finest dentistry and best care possible.

Financial Responsibility

Insurance:
Our office verifies eligibility and benefits for all patients. Patients MUST take note: all insurance companies have a disclaimer that any information that they provide is NOT a guarantee of coverage and or payment. Therefore, any balance after insurance payment is the sole responsibility of the patient.

We have many payment options available:
Cash, personal checks (there will be a $50.00 charge for all returned checks), all major credit cards and outside financing available.
I hereby guarantee payment of all charges incurred for the account of the above mentioned. I realize that insurance may not cover the amount charged and that I will be responsible for the balance left after insurance. I understand that balances not paid timely are subject to additional charges and or collection procedures.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Dental Consent:
I have completed a health history and have reviewed past and present medical conditions with the dentist. Anticipated dental treatment will be discussed with me in person and any changes to the plan will be made known to me.
If there is no insurance coverage available, I understand that I am responsible for all charges incurred at the time of service.

Print Patient Name:_____

Signature: _____Date: _

Doctor Signature:_____Date: ___

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