Office Policies

Financial Policy

All dental services performed must be paid for in full at the time services are rendered, unless previous financial arrangements have been made. We accept cash, check, Visa, MasterCard, or Discover. We also offer patient payment plans through the financial company Care Credit.

Insurance

We may accept assignment of insurance benefits and we require your estimated copay and patient portion to be paid on the day of treatment. As a courtesy to our patients, we submit all insurance claims for you. **You are responsible for knowing the benefits and exclusions of your policy.** If your insurance company has not paid in 45 days, the balance is then your responsibility. The estimated fee listed for dental care can only be extended for a period of six months from the date of the patient examination.

Collections

The patient agrees to pay all costs and reasonable attorney fees if a suit is instituted hereunder to collect monies owed. By signing, the patient authorizes the release of financially identifiable information concerning their account including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary. The undersigned further agrees to pay an additional amount representing up to 33% of the principle balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

Minors

The parent or guardian that is accompanying any minor is responsible for full payment. We do not bill secondary parties (such as ex-spouses) for payments. For unaccompanied minors, payment arrangements should be made prior to the appointment.

Missed Appointments

Your appointments with our office have been reserved especially for you. We are a private practice and we value our time with you. We do not overbook our schedules, thus making you wait unnecessary amounts of time. As a courtesy we may call to remind patients of their appointment. As a courtesy in return, please come to your appointment on time and give us a 24-hour notice if it is necessary to cancel. **Without a 24-hour notice on any cancellation, a $25.00 charge will be applied to your account.**

I grant permission for this office to telephone me or leave a message at my home or at my workplace to discuss matters related to this form and to remind me of my appointments.

I acknowledge that I have received a copy of this office's Privacy Policies. I authorize this office to release identifiable and treatment information to my insurance carrier and to any other related entities that require information regarding my dental care.

I hereby agree to abide by the conditions outlined herein

______________________________ _____________ _________________

Signature of Patient or Legal Guardian Date Relationship to Patient