

OFFICE POLICIES

Please arrive at your scheduled appointments on time, and with photo ID, insurance cards, and insurance co-pay if applicable.

Financial Responsibility:

- The patient (or guardian if under 18) is ultimately responsible for all charges associated with their dental care, regardless of insurance coverage. We strive to make your dental care as cost efficient as possible.
- Payment will be collected at the time of service. If you are unable to pay for service in full at this time, financial arrangements must be established before treatment.
- All patients who are seen in our office for a comprehensive exam are provided with a treatment plan. This is only an **ESTIMATE** of the anticipated cost of your dental treatment. It will include an **ESTIMATED** insurance payment based on your plan coverage. If your insurance carrier's payment differs from our estimate, you are held responsible for the remaining balance. **Any claims over 90 days become your responsibility** and you will receive a statement of services. The balance is due and payable by the 25th of the month. If there is a case of overpayment, you are entitled to a prompt refund.
- Any balance owed for more than **SIXTY days** will incur a 1% compounded monthly rate, or 12% annual fee. Anyone receiving a statement will incur a \$1.00 billing charge for each statement that is sent. **STATEMENTS will be sent AFTER we receive final payment from your insurance.**
- **If you do not have dental insurance, we offer a 5% cash or check courtesy at the time of service.** We accept VISA, MasterCard, Discover, Care Credit, Varidi, HAS, personal checks and cash as forms of payment.
- IF you have any questions regarding your account or are experiencing circumstances beyond your control, please contact our office. Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication.
- Please be advised that in the case of your account becoming delinquent, we do utilize the services of an outside collection agency.

Late Cancellation and No-Show Fee Policy:

- **A cancellation and/or no-show fee of \$50 will be charged to all patients who do not provide at least 48-hour notice to cancel their appointment, or to those who fail to show up to their scheduled appointment. Messages that are left while the office is closed, will not be considered 48-hour notice, and will be subject to a \$50 fee. Please call during business hours. *PATIENT INITIALS: _____**

Treatment of a Minor (under the age of 18):

- If a patient is under the age of 18, **a parent/guardian must be present at the time of the new patient appointment.** The parent/guardian is responsible for the patient's copay and referral needs or other insurance requirements at the time of service for all scheduled appointments.

Patient Name

Date

Signature of Patient, Parent/Guardian (If patient is under 18)

Date