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OFFICE POLICY, PROCEDURES AND INFORMATION

Thank you for choosing our office for your dental care. We are committed to the success of your treatment. The following information is to help you reduce any uncertainty as it pertains to the office's practice in regard to fees, cost-shares, payments, billing and canceling of appointments.

PAYMENT
Payment is expected at the time the service is rendered. If you use your insurance benefits, your cost-share is determined by your **insurance plan** and can include a deductible. Payment of the cost-share and deductible is considered your responsibility and not that of the insurance company.

INSURANCE
We are contracted with most insurance companies PPO plans and will use the "schedule of maximum allowable charges" as our fee basis for covered services. We always attempt to provide you with an accurate estimate. We contact your insurance company to obtain the most updated information regarding your policy.
However, information regarding covered procedures rendered at another office may not be available, and they may affect your future coverage. Any portion that your insurance denies will be your responsibility to cover. Therefore, it is your responsibility as the patient to fully understand your dental insurance policy.

CANCELLATIONS AND MISSED APPOINTMENTS
We will confirm your appointment 48 hours prior to your scheduled time. We will confirm via telephone, email or text message (please make sure we have your updated numbers). If you have a hygiene appointment, we will also send a postcard 2-4 weeks prior to your appointment. We ask that you give us a return call, email or text so that we know that you are confirmed.
We ask for at least 24 hours notice if you need to change your appointment time. This gives us the chance to schedule another patient in your place. We do charge a $75.00 per scheduled hour fee for patients who are not present for their scheduled appointments and for patients who fail to give us sufficient notice that they have a conflict.
Patients with a history of failing appointments or repeated late cancellations may be dismissed from the practice.

By initialing here, I acknowledge that I am aware of the missed appointment policy ______(initials).

OTHER FEES/CHARGE Returned checks will be subject to a $35.00 fee. When an outstanding balance has to be forwarded to our collection agency, you will be responsible for any collection costs incurred. Any questions regarding these policies and procedures should be directed to our Office Manager at your initial visit. Your signature indicates that you understand and agree to comply with these policies, payment agreement and procedures.

____ ____________________

Signature of Patient or Responsible Party **Date**

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