OFFICE POLICY AND CONSENT FORM

Thank you for choosing our practice for all of your dental care needs. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. These financial guidelines are intended to facilitate excellent service to you while minimizing our administrative costs.

INSURANCE AND PAYMENT POLICIES

* **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
* For patients with Dental Insurance:

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

* Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash. Outside financing is available through Care Credit and Compassionate Health Care upon request.
* Regarding divorce and billing problems: This office is not a party to any divorce decrees. We may bill the responsible party (or guardian) that is present for treatment. Any collection fees, court costs, reasonable attorney fees, or returned check fees are responsibility of the adult person(s) named on the account.

OFFICE POLICIES

* Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments.  **If you must change or miss an appointment, we require a 2 business days’ notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $50.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $50 cancellation fee will be assessed for the first individual and $25 for each family member thereafter.**
* Our office will provide confirmation calls, emails and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm you appointment. Failure to do so may result in your appointment needing to be rescheduled.
* We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
* We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
* Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date Signature \_\_\_\_\_\_\_\_\_(Patient, Parent or Guardian)