

PRACTICE POLICIES

CANCELLATION POLICY:

QUALITY DENTISTRY REQUIRES AN APPROPRIATE AMOUNT OF TIME AND EACH APPOINTMENT IS SCHEDULED EXCLUSIVELY TO MEET YOUR NEEDS. CANCELLATIONS WITHOUT A 48 HOUR NOTICE WILL INCUR AN APPROPRIATE CANCELLATION FEE.

DO YOU WISH TO BE CONTACTED TO CONFIRM YOUR APPOINTMENTS WITH OUR OFFICE? YES _____ NO _____

IF YES, PLEASE INDICATE BELOW YOUR PREFERRED METHOD OF CONTACT:

- 1. HOME TELEPHONE _____
- 2. CELL PHONE _____
- 3. WORK PHONE _____
- 4. TEXT MESSAGE _____
- 5. E-MAIL _____

FINANCIAL/INSURANCE POLICY:

PAYMENT IS DUE WHEN DENTAL SERVICES ARE RENDERED.

IF YOU BELONG TO A TRADITIONAL INSURANCE PLAN WE CAN ASSIST YOU BY FILING YOUR INSURANCE CLAIMS. TRADITIONAL INSURANCE IS TYPICALLY ONE IN WHICH YOU CAN CHOOSE ANY DENTIST YOU DESIRE. OUR PRACTICE DOES NOT BELONG TO ANY PPO OR DMO INSURANCE PLANS. IF YOU ARE NOT SURE WHAT TYPE OF PLAN YOU HAVE, WE WILL BE HAPPY TO CALL FOR YOU AND EXPLAIN YOUR BENEFITS TO THE BEST OF OUR ABILITY.

IF YOU HAVE DENTAL BENEFITS, YOUR PORTION OF THE CHARGE IS DUE AT THE TIME OF SERVICE. DENTAL SERVICES ARE PERFORMED BASED ON YOUR PERSONAL NEEDS NOT THOSE OF YOUR INSURANCE COMPANY.

*******I UNDERSTAND THAT I AM RESPONSIBLE FOR THE TOTAL BILL REGARDLESS OF THE BENEFIT AMOUNT. IF MY DENTAL BENEFITS ARE NOT PAID WITHIN 30 DAY OF SERVICE, I UNDERSTAND THAT THE BALANCE IS THEN DUE FROM ME. I AGREE TO PAY A REASONABLE ATTORNEY'S FEE IF COLLECTIONS IS NECESSARY.**

SIGNATURE OF PATIENT OR GUARDIAN

DATE: _____