OFFICE POLICY

Patient Name:____Date of Birth:______/_____/______Age:________
Last First MI

DENTAL INSURANCE POLICIES

Dental benefits are not meant to determine your dental care; they are to assist you in the payment of your treatment.

We are not responsible for determining what your particular benefits are. Most policies cover what they consider a "usual and customary fee". However, the insurance company establishes these fees to meet their needs, and they are not always the same as the fees that may be charged in our office.

We will do our best to see that you receive your full benefits. However, ultimate responsibility for payment is yours and financial arrangements must be defined before dental treatment begins.

You are responsible for portions not covered by your policy on the day of service.

Your insurance policy is a contract between you and your insurance company. Any problems of non-payment or delay of payment are your responsibility.

Any insurance balance over 60 days old is delinquent and is your responsibility to pay.

Assignment of benefits and release of information

I authorize payment of dental benefits to the named provider for professional services rendered; and I authorize the release of any dental information necessary to process this claim.

OFFICE POLICIES

In the event of broken appointment, or cancelled appointment with less than 48 hours' notice, there will be a fee of $50 for every half hour of your dental appointment during weekdays and $100 for every half hour for Saturday appointment.

I understand payment or co-payment (insurance patients) is due and payable in full at each appointment visit. In the event that this account becomes past due; the doctors, their assigns, or lawful agents may immediately consider the account in default and pursue collection procedures. Collection costs may include, but not limited to court fees, collection and attorney fees. If my account is past due I agree to pay 1.50% interest per month (21% annum) on the unpaid balance from the date due, in addition to a recovery charge of $40.00. Any returned check will be charged a processing fee of $40.00.

<u>Any appointments one hour or longer will require 1/3 deposit to reserve the appointment time.</u>

I grant my permission to you or your assignees to telephone me at work to discuss matters related to this form.

I guarantee this form was completed correctly to the best of my knowledge, and understand that it is my responsibility to inform this office of any changes to my contact numbers, address information, email address, and any changes to my health or prescriptions. I also read, understand and agree to the office policy.

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Signature of: Patient Parent/Guardian Other:

Date:_______/_______/_______