MP DENTAL & ASSOCIATES, DDS PC

OFFICE POLICY & FINANCIAL INFORMATION- **PLEASE READ CAREFULLY**

It is the goal of our practice to provide the finest care available. Patients will be scheduled for treatment after financial arrangements are made in writing with our Financial Associates regarding all treatments.

Appointments are reserved specifically for you. In consideration of this our office requires a 24 hour notice if you are not able to make your appointment. If we do not receive this notice, a fee will be charged to your account.

X-rays Requirements— We pride ourselves in delivering the highest standard of care; therefore, complete diagnostic x-rays are necessary. Fees for necessary x-rays, if any, will be disclosed before taken**.**

Insurance Policy--- Patient copay of his/her portion is due at the time of service. As a courtesy to all of our patients with insurance, we will file claims for dental services with your primary insurance company, and if applicable your secondary insurance. The normal time allowed for insurance payment is 30 days. Any balances remaining on your account after 30 days is your responsibility.

Payment Policy--- Our office requires payment in full for all services rendered at the time of visit, unless other arrangements have been made in writing with the financial department. If a payment plan is needed then you authorize MP Dental to make inquiries with any credit bureau regarding your financial history.

Collection Policy--- Unpaid accounts over 90 days become delinquent and if no financial arrangements have been made in writing you will be responsible for legal fees, interest charges, 33 1/3% attorney fees, and any other expenses incurred in collection of your account balance.

AUTHORIZATIONS FROM PATIENT

I authorize MP Dental to perform any necessary services needed during diagnosis and treatment and to release any required information to outside health practitioners and for the purpose of processing insurance claims.
I understand that my insurance policy is a contract between me and my insurance company(ies) and that I am responsible to MP Dental for all fees.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual billed services and that I am responsible for the remaining balance.
I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office within 30 days of any changes to the information I have provided.

All treatment is guaranteed for 1-year and will be replaced at no cost to patient for same treatment type if a defect on material or technique is detected. Guarantee will be extended to 5 years if a patient keeps their preventive cleaning once every 8 months at the most (NO EXCEPTIONS).
I understand additional procedures are sometimes necessary (at patient's cost) to achieve a successful treatment. All treatments must be complete within 3 months of starting date otherwise patient will be responsible for a new FULL FEE. Arrangements made in writing are excluded.

PLEASE NOTE: MP DENTAL PARTICIPATES WITH THE **PRESCRIPTION MONITORING PROGRAM**

Signature _____ Date _____

_____Adult _____Parent or Guardian _____ Spouse's Signature (Power of Attorney Required)