

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. In order to provide the best dental care, our office promotes a friendly mutual understanding among staff, doctor and patient. If any problems or questions arise, do not hesitate to bring them to our attention immediately.

FINANCIAL POLICY

1. Insurance benefits must be assigned to us if payment in full is not made at the time of service. Regardless of insurance benefits available, **the entire balance is the patient's responsibility.**
2. Interest will be charged on a monthly basis on any unpaid balance.
3. Delinquent accounts will be turned over for collection and all cost of collection, including attorney's fees (not to exceed 20%), will be charged to the account.

FEES

We make every effort to keep the cost of your dental care to a minimum. Our fees are based on the time involved doing the procedure, the level of skill required, the caliber of people who work in our office, our facility and equipment, the continuing education of all staff members, the quality of materials used and laboratory costs.

PAYMENT OF SERVICES

Fees are due and payable at the time of your office visit. A repeat charge of \$2.00 is added to accounts over 60 days old from the date of service. **We accept cash, local checks, money orders, Mastercard/Visa, American Express and Discover.**

INFORMED CONSENT

When treatment is accepted, you are agreeing to be financially responsible for all charges incurred regardless of insurance coverage. At your visit, all of the visual, clinical and any x-ray information will be assembled and the findings will be discussed with you. We will explain the various options available for your treatment and the benefits you may expect. Upon your request, we will inform you of treatment costs.

APPOINTMENTS

In order to provide timely and effective care to all our patients, **we request that appointments be made for all office visits.** We always attempt to see our patients at their appointed time and, therefore, we ask that they be punctual. Patients arriving 15 minutes late may be asked to reschedule as a courtesy to the patients that following them. Generally, we call to confirm each patient the day before a reserved appointment time. Occasionally, one has to leave a message with a family member, on an answering machine, or either we are unable to reach someone to confirm the appointment. **However, it is the patient's obligation to remember the appointment they scheduled with us regardless of receiving or not receiving a confirmation call.** Please keep us aware of your changing addresses and phone numbers. We request that you do not wait until we call to confirm your appointment to cancel. This places us at a disadvantage for treating other patients needing care. This will qualify as a short-notice cancellation and a broken appointment fee will be rendered.

BROKEN APPOINTMENTS

Our office maintains a strict policy regarding broken appointments. A broken appointment is defined as any reserved block of time scheduled for a patient which that patient either verbally canceled less than 48 hours before due, or no shows. If you break an appointment twice, we request a call the day you wish another appointment. We will be happy to see you if there are any openings for that day. Also, before rescheduling a patient, the broken appointment fee must be received by the office. It is necessary for us to enforce this policy to everyone in order to be fair to all patients. We hope that this policy will encourage patients to keep their appointments and receive timely dental care. It will also decrease the waiting time for all patients to be scheduled for treatment in our office.

We understand that situations may arise that may not permit a 48 hour notice. Exceptions to this policy will be determined on an individual basis according to the circumstances.

Thank you for your understanding and cooperation.

I have read and understand the office policy as outlined above, and agree to these conditions.

Patient (Guarantor)

Signature _____

Date _____