OFFICE POLICIES

We feel that everyone benefits when there is a clear understanding of our office policies prior to treatment.

THE INVESTMENT necessary to complete your treatment is based on a recommendation derived from your examination. Should additional services arise as treatment progresses, this recommendation may have to be revised. You will be consulted before any unexpected treatment is undertaken. Recommendations made will be honored provided treatment is completed within six (6) months of the initial examination date.

INSURANCE *is a contract between you and your insurance company.* In most cases, we are not a party to this contract. As a courtesy, we will send the claims for you. Although we may estimate what your carrier may pay, it is the insurance company that makes the final determination of your eligibility and any benefits paid. It is ultimately the patient's responsibility to know and understand what services are covered under their individual insurance policy, as well as if your plan is in network with our providers. If any changes in your insurance coverage are not provided within the carriers' timely filing period, the patient will become responsible for any balance on the account. You agree to pay any portion of the charges not covered by the insurance company. A credit balance and/or overpayment can result from an amount greater than expected, duplicate payments and account adjustments. Accounts with credit balances or overpayments will be researched and analyzed for accuracy. Credit balances that result from patient overpayments may be used for future treatment or requested in the form of a check. Requested refunds will be issued up to 90 days after requested and if applicable, after insurance carrier's final determination. Insurance overpayments will be returned to the insurance company. Please note we do not accept nor participate with DMO/HMO insurance plans, prepay plans, or discount plans.

REQUIRED PAYMENTS are due at the time of service. Insurance co-payments are estimated and you may receive a statement for any balance remaining after the insurance payment is received. Prosthetic services may be paid in two installments. Fifty percent (50%) on the start date and the balance on the completion date. **We accept cash, personal checks, Visa, Master Card and Discover. Another option is Care Credit, which is a credit plan for dental services. Please inquire if you are interested.**

HIPAA: A HIPAA form must be signed for our office to be able to share information with insurance companies and other service providers.

BROKEN APPOINTMENTS are disruptive to our practice and we lose valuable time which could have been given to other patients who need our services. When an appointment is made, we consider that a commitment that you will be here. As a courtesy, we will call and confirm with you two days before your appointment. We do ask that you call back and verify that you will be here at your appointed time. **We require at least 24 (business) hours' notice to change an appointment. There may be a $70.00 fee for any failed appointment or last-minute change to an appointment. Failure to arrive at the scheduled appointment time may result in an automatic dismissal from the practice.**

DIVORCE: In case of divorce or separation, the person receiving treatment will be the responsible party. With regards to children, the parent authorizing treatment will be the responsible party. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parents responsibility to collect from the other parent.

RETURNED CHECKS: Returned checks are assessed a fee by our bank. We must charge a $25.00 fee for any returned checks.

PAST DUE ACCOUNTS: If your account becomes past due, we will take the necessary actions to collect this debt. If we have to refer your account to a collection agency or an attorney, you agree to pay all collection and any court costs that are incurred. The collection agency we use is IC Systems, Incorporated.

TRANSFERRING RECORDS: You will need to authorize any records to be transferred. Records will be sent to other dentists as a courtesy via email. Records printed will require a transfer fee to be paid.

I understand that I am financially responsible to this dental office for all charges incurred by myself and/or my dependent(s). There is interest added at 1.25% per month on accounts not paid in full after 90 days.

Patient Name (Printed): _____ **DOB:** _____

Signature: _____ **Date:** _____