

OFFICE POLICIES

Our philosophy is to provide the highest quality of patient education and dental care to all of our patients. To ensure that you begin with a positive experience we have prepared the following information for you to review. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT

In order to keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience we will provide you an estimate for services in advance of your appointment/s to ensure you opportunity to plan in advance for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

Initials

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We ask that you familiarize yourself with your insurance benefits, and provide us the correct information for the submittal of your claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 60 days. Please remember that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee any estimated coverage. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

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PAYMENT OPTIONS

For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service.

Cash or Check _____ Visa / MasterCard _____ Extended Payment Options _____ (Please see below)
Should you desire a monthly payment plan we invite you to complete a simple finance company application. There are no application fees or a down payment and the loan can be interest-free. Approval is provided to you quickly.

PAST DUE BALANCES

Any balance owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 60-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. All balances over 60-days are subject to a \$10.00 rebilling fee.

Initials

CANCELLATION NOTICE

If you are unable to keep an appointment that has been reserved for you, we request that you provide us with a 24-48 hour courtesy notice. The earlier you notify us ensures that we can offer you a more convenient appointment and it allows us more time to invite another patient in for the care they need filling the open time you are unable to keep. We realize that emergencies do occur and we will be flexible under those circumstances; however, other missed appointment without the requested notice may incur a \$50 fee. Please be advised that three (3) missed appointments without the requested notice within a 12-month period of time may result in dismissal from our practice.

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INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to your medical history, telephone number/s, address, employer or insurance information as they occur.

Initials

My signature indicates that I understand that policies as outlined and any questions I have with regard to office policies have been answered.

Signature of Responsible Party or Patient

Date

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

Signature of Staff Member or Doctor

Date

Vital Information about your Dental Insurance

Our office is happy to help you file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. Your Employee Benefits Director can usually help you become familiar with your plan and its' restrictions, and our office will assist you in maximizing your benefits.

Our responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60 day period.

Your responsibilities:

1. To pay fees not covered by your plan at the time of treatment.
2. To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
3. To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
4. To pay any account balance not paid by insurance after 2 billing attempts.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign this form below. We will keep one copy in your chart and will give you one copy for your own records.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.

Patient or Insured

Date