

## Information About Your Dental Service

We feel strongly that our patients deserve the best care. In an effort to provide high quality dental care we would like to share information with you about our office policies.

- ❖ If you do not have any dental insurance benefits we require payment in full at time of service. We accept cash, check, debit card, Visa, MasterCard, Discover and American Express.
- ❖ As a courtesy we will bill your dental insurance for you; this does not make us responsible in any way for knowing all the details of your contract. In some cases, the design of your plan may limit your benefits and may not cover all necessary treatment. We encourage you to read your benefit booklet which your employer should provide or you should have access to.
- ❖ If you choose for us to bill your dental insurance and the services you are receiving are covered at less than 100%, then you will be asked to pay that portion on the day of service. Any good faith estimate of dental benefits we give you, either written or oral, is just an estimate and **not a guarantee of benefits**.
- ❖ When you make an appointment at our office we reserve a block of time just for you. If you call at the last minute or no show then the time goes unused, we do not double book our schedule. We ask that you kindly give us **48 hours notice to reschedule or cancel** an appointment time you have reserved with us. If appropriate time is not given then we reserve the right to charge your account \$75.00 per hour reserved.
- ❖ Accounts over 90 days will be charged 1% interest per month. Accounts over 120 days will be sent to a collection agency.
- ❖ There is a charge of \$50.00 for checks returned due to insufficient funds.

### Treatment and Insurance Payment Authorization

I hereby authorize payment directly to my Doctor's office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize my Doctor's office to administer such medication and perform such diagnostic and therapeutic procedure as may be necessary for proper dental care. I certify that all of the above information is correct and I have read and will subscribe to the office policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_