Statement of Office Protocols

FINANCIAL POLICY

Thank you for choosing our office as your child(ren)'s dental health care provider. We are committed to providing the highest quality dental care, so that your child(ren) may attain optimum oral health. Please understand that payment of your bill is considered part of their treatment. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, and VISA/MC/Discover/American Express cards.

If you have insurance benefits, we ask that you pay the deductible or the estimated co-payment at the time of service. As a courtesy to our patients, we will submit the insurance claims for you; however, your insurance is a contract between your employer and the insurance company. All patients are financially responsible for their accounts. The insurance company is responsible to the patient. We want to emphasize that as your dental care provider; our relationship is with you, our patient, not with your insurance company.

All charges you incur are your responsibility regardless of your insurance benefits. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however enter into a dispute with your insurance company over any claim. If problems arise in getting a claim paid, specific questions should be directed to your insurance carrier or your employer.

Insurance payments are ordinarily received within 20-60 days from the time of filing. If your insurance company has not made payment within **45 days**, we may ask that you contact your insurance company to make sure payment is expected. If payment is not received within **90 days** from the date of filing, or your claim is denied, you will be responsible for paying the full amount at that time. If we receive any payments from your insurance company after you have paid your bill in full, we will remit the payments directly to you.

APPOINTMENT POLICY

We respect the importance of your time and we work very hard to schedule appointments that accommodate the scheduling needs of all our patients. We want you to know that we make every effort to see your child(ren) at your scheduled appointment time. We feel that a successful outcome to treatment is the result of combined efforts of both you and this office. Therefore, it is important to adhere to the recommended treatment schedule to obtain optimum results. If you must cancel or reschedule an appointment, we would greatly appreciate that you notify us at least **one business day prior** to your scheduled appointment time. Broken, missed appointments, as well as late arrivals create scheduling problems for other patients as well as the practice. Appointments are considered reservations and you will receive a reminder email/text or call prior to this appointment. If we are unable to reach you, we trust that you will keep your reserved appointment. Repeated late cancellations or rescheduling will force us institute a $50 fee per child per instance. This must be paid prior to being scheduled again at our office. We ask for your careful consideration regarding this matter. In return, we promise to provide you with the very best dental care.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS REGARDING THE FINANCIAL AND APPOINTMENT POLICY FOR THIS PRACTICE. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

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Patient Name (PRINT CLEARLY)	**Signature of Guarantor, if Minor**	**Date**