Patient Agreement

Insurance Benefits

Dental insurance is intended to cover some, but not all, costs of your dental care. Most plans include co-insurance provisions, deductibles, and certain other expenses which must be paid by the patient at the time of service. If we are a participating provider with your insurance company, the total fee we may receive including the insurance payment and the patient portion are set by the insurance company. A special note on fillings and crowns: our office only offers composite (tooth-colored) fillings and porcelain crowns, as these are the most appropriate materials for optimal patient care. Some insurance companies only pay a reduced amount for lesser materials, and the patient is responsible for any difference in fees. If you have any questions about your insurance coverage for these procedures, please contact your insurance company. We submit claims to your insurance company as a courtesy only, and you are ultimately responsible for any amounts not covered by insurance.

_____ (initial)

Financial Responsibility

We accept cash, checks, major credit/debit cards and Care Credit. ***Payment, less estimated insurance if any, is due at time of service***. If financial assistance is required, arrangements must be made prior to the onset of treatment. If you have dental benefits, we will do our best to **estimate** your portion. Exact patient portions can not be determined until insurance payments are received and may differ from the estimate. Any account credits may be refunded at your request or applied to future services. Statements for remaining balances are mailed following receipt of your insurance payment and are expected to be paid in full unless prior financial arrangements have been made. A service charge of 1.5% (18% APR) may be applied to account balances not paid within 60 days. In the event that your account must be sent to a collection agency for non-payment, you will also be responsible for all costs of collections, court fees and attorney fees. A $25 service fee will be assessed for all returned checks.

_____ (initial)

Scheduling Guidelines

We respect your time and make every effort to stay on schedule. We hope you will understand and respect our time as well by giving us **two business days'** notice to change or cancel an appointment. This allows us to make that time available to other patients that may have immediate needs. We reserve the right to charge a $40 ***broken appointment fee*** (amount subject to change without prior notice) to offset the cost of unused staff time. This is intended not to penalize patients who may have an illness, family emergency or other unavoidable conflict, but to discourage repeated abuse of our scheduling process. If you are late for your appointment, circumstances may require that we reschedule you and the broken appointment fee may apply.

_____ (initial)

Privacy Practices

Our Privacy Practices are posted on our website and in our office, and copies are available upon request. In summary, we will use and disclose your personal health information only for purposes of treatment, payment and healthcare operations, not for marketing or any other uses. Your signature below acknowledges that you understand that you have access to full information about our Privacy Practices, that we will issue a revised notice of Privacy Practices if we significantly change them, that you consent to our use of your health information as outlined above, and that you may revoke this consent at any time by giving written notice.

I have read and understand the information above, and I have had an opportunity to have all my questions answered.

Patient's (or Legal Guardian's) Signature Print Patient Name Date

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