Office Policies

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policies.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand full payment and/or copayment is due at time of service. I understand there is a $35 processing charge for non-sufficient funds or returned checks. Payments not made within 14 days of service will accrue at 18% per annum (1.5% per month). Should my account be turned over to a collection attorney or agent, I am responsible for all costs, legal fees, and expenses incurred in the collection.

As a courtesy to me, I understand this office will file any dental insurance for me. I acknowledge that insurance is a contract between myself and the insurance company and that this office cannot guarantee any payment from the insurance company. I hereby authorize the prompt release of any information needed and authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, I agree to pay the full remaining balance.

I understand this office will provide me with an estimate of benefits, however I am responsible for being aware of what my benefits are. Ultimate responsibility for payment is mine and I am obligated to pay this office in accordance with its credit terms and policy.

As a condition of treatment here, I understand that I must have a current full mouth series of x-rays or a panoramic x-ray and set of bite-wing x-rays (less than a year old) before my initial hygiene visit. I authorize the doctor and his staff to take any x-rays, models, photographs, or scans deemed necessary by the doctor to make a thorough diagnosis. Upon diagnosis, I authorize the doctor and his staff to provide all forms of treatment, medication, anesthetic, and therapy that may be indicated in connection with my dental health.

I understand that if I no-show or cancel more than one appointment with less than 24-hour notice, there will be a failed appointment fee of $50/hour booked, which I agree to pay before any further appointments can be made.

We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment. If you miss an appointment, we ask that you call to reschedule. I understand that it is my responsibility to confirm all appointments as it is critical to my health to avoid setbacks.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Patient/Parent/Guardian Signature (Responsible Party) Date