**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 that payment is due at the time of service. I understand there is a $25 monthly late fee if I do not pay my balance within 30 days of a statement due date. There is a $35 processing charge for non-sufficient funds or returned checks. I understand that in order to collect any debt, my credit history may be checked through use of my social security number and any other information given. Should my account become delinquent and turned over to a collection attorney or agent, I am responsible for all costs, legal fees, expenses, and court costs incurred in the collection.

I grant permission to this office to phone, email, or text me to discuss my account, appointments, or treatment.

I understand that this office will always do the best to help maximize my dental benefits and provide me with an accurate pre-treatment estimate. However, before any treatment, I understand that my insurance coverage must be verified. It is my responsibility, therefore, to provide this office with accurate insurance information so that a claim can be submitted. If insurance eligibility cannot be verified, all treatment will need to be paid in full at the time of service.

As a courtesy to me, I understand this office will file any in-network insurance for me and accept the direct payment of benefits accrued under my policy. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

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, photographs, models, or scans deemed necessary by the doctor for diagnostic or demonstration purposes. Upon diagnosis, I authorize the doctor and his staff to provide all forms of treatment, medications, anesthetics, and therapy mutually agreed upon by me in connection with my dental health. I understand that I may ask and have my questions answered about possible risks and complications.

We ask that you be on time for your appointments and no more than 10 minutes late. I understand that if I miss or cancel an appointment with less than a 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.

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

______________________________________________ ____________________

Patient/Parent/Guardian Signature (Responsible Party) Date