Smoketown
FAMILY DENTISTRY

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Office Policies

Thank you for selecting us as your personal dental care team. To promote a long-term mutually satisfying relationship, we would like to explain our office policies regarding treatment, insurance, appointments and fees. Please read this carefully and ask any questions or bring up any concerns you may have before treatment is rendered. SUBMISSION TO TREATMENT IMPLIES YOUR CONSENT TO THE TERMS OF THIS AGREEMENT.

TREATMENT: You will find our entire staff is dedicated to helping you improve your dental health. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at any time.

INSURANCE: If this office is able to accept your insurance company's assignment, the patient is still fully responsible for the charges for treatment rendered. Your insurance may not cover the services or may only partially cover them. Any estimate given by this office is considered a guideline until the final insurance is received and the patient's account is reconciled. The office can make no guarantee of the actual payment by your insurance company.

MISSED APPOINTMENTS: When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us **at least** 24 hours notice when you realize you cannot keep an appointment. When the requested notice is not given, a fee will be charged.

PAYMENT DUE AT THE TIME OF SERVICES: We accept cash, personal checks, MasterCard, VISA and Discover. When insurance applies we will collect any deductible and estimated co-pays at this time.

We have payment options available for patients needing extensive dental work. The payment option must be approved before services are rendered. Please ask the receptionist for more information if interested.

SERVICE CHARGES:

1) RETURNED CHECKS: There is a fee for returned checks. Upon notification that your check was returned, cash must be brought in immediately to cover the check and the returned check fee.
2) COLLECTION FEES: Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay required these fees to be incurred.

Signed this _____ day of _____, 20 ____

Patient Name (please print): _____

Relationship to Patient: _____

Signature: _____