Office Policies

Patient Name: _____ Date:_____

Insurance

As a service to you, our office will submit an insurance claim for payment to your dental insurance company on your behalf. Your dental insurance policy is a contract between you, your employer and the insurance carrier. In most cases, your insurance company will not provide our dental office with your insurance details. Please speak to your carrier directly to obtain this information. It is the account holder's responsibility to understand the coverage and benefits of the patient's dental plan.

Payments

Our office is non-assignment of benefits; full payment by visa, mastercard or debit is required at the time of service. Claims are submitted by the dental office whenever possible; reimbursement is to the patient directly.

Any multi-visit service may require a percentage deposit at the first visit and/or equal payments at each visit. This is to help cover any work performed, lab fees, office expenses, supplies, and materials used during treatment and any remaining portion is expected at the completion visit.

Missed Appointments

We appreciate that it may become necessary to reschedule an appointment. Please understand that this appointment has been reserved specifically for you. In order to accommodate the needs of our patients, we require two business days' notice in order to change your appointment. Each person's situation is different, and we realize that family, office emergencies, and illness can arise. We will be pleased to discuss the details of short notice appointment changes on an individual basis. Please be aware that fee may be incurred if we receive insufficient notice to change your appointment.
We do our best to contact patients to remind them of upcoming appointments but respectfully ask that you create a reminder of your own and confirm your schedule.

I hereby authorize (1) the release of my dental health care information for any of my dental insurance claim forms, (2) the use of my dental records by my dentist in any professional manner that she/he determines, (3) the making of videos, photos, and x-rays of my dental care treatment (collectively "My Images), and (4) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I certify that I have read or have had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

Signature of Patient/Responsible Party:_____ Date:_____

Printed Name of Responsible Party: _____