

TO OUR PATIENTS

Thank you for choosing us to provide you dental care. We will do our best to continue to earn your confidence. We are dedicated to providing you with the most comfortable and technically up-to-date dental care and taking continuing education to stay abreast of current advances in treatment. Nitrous oxide sedation and oral sedation are available upon request.

When you have an appointment with us, we will do our best to see you promptly. We feel that your time is just as important as ours and we hope that you feel the same. Arriving late is sometimes unavoidable but can cause a problem for our scheduled patients, therefore our policy is: If a patient arrives more than 10 minutes late, we will evaluate our schedule to determine if the patient may be seen. In some instances the patient may be asked to reschedule. If you need to change an appointment, we require at least 24 hours notice, (Monday would have to be changed by Friday). A broken appointment will be charged at a rate of \$85.00 per hour. Should a patient continue to break appointments, we reserve the right to dismiss that patient from the practice.

Our office will be happy to work with your insurance to make sure you get maximum coverage. Please remember that we have no control over the benefits of your plan.

*****If there is an unpaid balance on your account, you will receive a billing letter allowing you 10 working days to pay; at that time if we have not received your payment—your choice below will be debited. I understand that any portion of the estimated amount not paid by my insurance company and claims not paid within 60 days will be my responsibility. **Please remember you are the one who chose your insurance and it is your responsibility to be aware of what your contract benefits are.**

For your convenience we have 2 ways to handle your claims: Please read, provide the necessary information, and sign under your choice. **PLEASE CHOOSE ONE.**

1. I choose to have my insurance company pay their portion to your office. I wish to put any unpaid balance on my credit card.
Debit/Credit Card Number: _____ Exp Date: _____
Signature Panel 3 Digits on back of card (CID) _____
2. I choose to pay the entire fee myself and have the insurance company reimburse me. I understand I must pay the entire fee at the time services are rendered.

PLEASE SIGN BELOW— I HAVE READ AND UNDERSTAND THE POLICIES.

Print Name

Date

Signature