

## PRACTICE GUIDELINES

It is our goal to provide you with the highest quality care possible.

### APPOINTMENTS

There will be absolutely no charge for your need to reschedule an appointment, provided we receive 48 hours notice. **Please contact us with your request during regular office hours.** This courtesy would provide us with the opportunity to offer this time to another patient. If proper notice is not given, we reserve the right to charge a **75 dollar cancellation fee and 150 dollar cancellation fee for root planning,** due to extra time being reserved.

### INSURANCE PATIENTS

If you have dental insurance, it will be our pleasure to process your insurance claim as a courtesy to you. We take pride in making every effort possible to obtain the maximum benefits allowable under your plan. We are happy to inform you that most insurance plans will pay a portion of your necessary dental treatment. **For your convenience, estimates will be provided before treatment is scheduled. With the magnitude of different dental plans and with constant changes in benefits, it is impossible for us to provide a guarantee of payment.** Since we are not involved in the contract with your employer and the insurance company, all treatment not covered and payable by the insurance plan will be your responsibility. Any claims not paid within 2 months shall become the sole responsibility of the patient. If your insurance company requests a refund from us for any reason, you will be required to reimburse the amount of that refund to this office within 30 days. **Payment is required at the time service is rendered.** Once coverage is verified, if the deductible has not been met, payment of the deductible is required on the first visit where the deductible would apply (usually does not apply to exams, cleanings or x-rays). The portion of the fee which your insurance does not cover is called the co-payment and that percentage is due in full at the time of service.

### CASH PATIENTS

Patients without dental insurance are offered a 5% bookkeeping courtesy, providing the charges are paid in full by check or cash before the start of treatment. This applies to treatment fees only, consultations or emergency visits are not included.

### AUTHORIZATION

I hereby authorize the Doctor to take x-rays, study models, photographs, or any other aides deemed appropriate by the Doctor to make a thorough diagnosis of my dental treatment, medication, and therapy. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between the insurance company and my employer and that I am fully responsible for services rendered. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance will be credited to my account, or refunded to me if I have paid the dental fees incurred.

**These Practice guidelines have been reviewed and explained to my satisfaction.  
All questions have been discussed.**

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_