183 Dentistry Office Policy

OFFICE HOURS
We are open Monday-Thursday from 8:00 am to 5:00 pm with the exception of being closed for lunch from 12:00pm to 1:00pm

INSURANCE
As a courtesy to our patients, we accept and can file most insurance claims for you. Insurance benefits are only estimates and the patient is ultimately responsible for any remaining balance.

PAYMENT FOR SERVICES
Payment is expected at time of service unless other arrangements are made in advance. We accept cash, checks, MOST major credit cards, care credit and insurance. You are responsible for any charges that your insurance does not cover. If your insurance company does not pay us within 60 days, you will be responsible for the remaining balance. Accounts over 90 days past due will be turned over to a collection agency.
There is a $25 charge for all returned checks.

BROKEN APPOINTMENTS AND LATE ARRIVALS
We require 24 hours notice if you need to change your appointment. You will be charged a $50 missed appointment fee PER hour scheduled. Broken appointments are those that have been cancelled with less than 24 hours notice. This fee is to cover the expense of setting up the treatment room, sterilizing the instruments and having the staff idle when they could be treating another patient.

DIVORCE DECREES
This office is NOT a party to your divorce decree. The legal guardian who accompanies the minor at the visit is responsible for payment.

INITIAL EXAMINATION
We require x-rays for your first examination. If you have current x-rays within the past year you will be responsible for obtaining your x-rays from your previous dentist, otherwise x-rays will be taken at the time.

INFECTION CONTROL
Our office meets all required federal and state infection control standards. All instruments are heat sterilized which kills TB spores, hepatitis, and the AIDS virus. Our dental unit water supply is self-contained, virtually eliminating the possibility of contaminated water lines.
This office policy is subject to change without notification

I HAVE READ AND UNDERSTAND THESE SERVICES AND POLICIES

Signature____ Date____________________

Print Patient’s Name____