EXPLANATION OF OFFICE POLICIES

Welcome to our office. This information is provided to answer any questions you may have as a new patient.

FINANCIAL RESPONSIBILITY

For our patients with dental insurance coverage: we will be glad to help you obtain the benefit information for your insurance plan and bill your carrier as a courtesy to you. You are responsible for the co-payment, which is the difference between our fee and the amount paid by your insurance carrier. (Even if you have double coverage, there may still be a portion that will be your responsibility.) Please remember that dental insurance benefits are based on a contract between you and the insurance carrier and you are ultimately responsible for your account if your carrier does not pay what is expected.

VERIFICATION OF YOUR DENTAL BENEFITS

We make every attempt to verify your eligibility and benefits prior to your appointment-that is why we ask you about your insurance before you have come in for your appointment. As hard as we may try, insurance companies are not always cooperative. If we are unable to verify benefits prior to your visit, you may be asked to pay the fees established by the office on the date of service. We will gladly provide you with a statement so that you may present this to your insurance company for reimbursement.

PAYMENTS, OVERDUE ACCOUNTS, AND INSUFFICIENT FUNDS

Payment is required for all dental care at the time of service. Co-pays are due before you see the doctor. If you do not have your co-pay we can reschedule your appointment for you so you can make arrangements to have it next time you come in. All private pay patients are required to pay for their visit today. Payment must be made in cash, check or a major credit card. Accounts due greater than 90 days are subject to an 18% annual service charge. In addition, if your account is referred for collections, you will be responsible for an additional 35% attorney fees. Checks returned by your bank are subject to a $30 bank processing charge in addition to the amount of the returned check.

PAYMENT METHODS

Master Card, Visa, Discover, and American Express are accepted for your convenience. We process all checks electronically.

REPORTING NEW INFORMATION

Communication is the key to successful relationships and this may all be applied to your relationship with our office. Kindly inform us of any changes in your insurance coverage prior to your appointment, address and phone number changes, or medical history.

CONFIRMING YOUR DENTAL APPOINTMENT

Please note your appointment time carefully; this time has been reserved exclusively for you. The office does routinely confirm your appointments by telephone as a courtesy.

KEEPING YOUR APPOINTMENT

Missed appointment times affect many people. The doctor and staff are prepared for your treatment and patients who have been waiting for treatment could have been seen at this time. Please be considerate and call the office to notify us of a cancellation at least 2 business days in advance. We understand that your time is important and we work hard to stay on schedule. Occasionally emergency procedures cause us to be delayed and we apologize in advance.

The fee for cancellation without a 2 business day in advance notice or no showing for an appointment is $25 per ½ hour of scheduled time for a regular appointment. Our computerized scheduler will automatically charge your account for any appointment change without sufficient notice. Please avoid this unpleasant situation for both of us by simply calling at least 2 business days in advance if you must reschedule. I understand that in order to reschedule an appointment I will need to pay 10% of total procedure nonrefundable deposit. This non-refundable deposit will go towards total procedure costs.

REQUEST FOR RECORDS

All patient records are the legal property of the doctor: however, we will gladly provide you with copies of your x-rays. In accordance with your dental plan and state guidelines, there will be a fee of $15 per patient for any dental records released. Treatment records are computerized and we will gladly provide you with a complete listing of services performed upon request.

DEVELOPING A RELATIONSHIP WITH YOUR CHILD

We are confident that you, as a parent, understand our need to develop a trusting relationship with your child. In our experience, we have found that we can more fully attempt to earn your child's trust if the child is unaccompanied by the parent into the treatment room. Frequently, the presence of a family member(s) may prevent the doctor and staff from developing a bond with the child, particularly if the child is "clingy". We want very much for your child's experience to be positive. It is also our intent to assist in helping your child develop good habits related to oral health that will last a lifetime. We request that you assist the treatment of your children by remaining in the reception area during their visits.

FOOD AND DRINKS

For health reasons, no food or drinks are permitted in the reception room, or the patient treatment rooms.

RECOMMENDED TREAMENT MAINTENANCE

Although, the office may assist you with reminder letters or telephone calls, it is your responsibility to complete the treatment plan and follow the recommended treatment maintenance program.

PREPARATION FOR YOUR APPOINTMENT WITH ANTIBIOTICS

If it has been determined that you require pre-medication for you're appointment with an antibiotic because of a heart murmur, heart valve replacement, joint replacement, dialysis, or other medical condition, please make certain to take your medication as requires to avoid rescheduling of your appointment and delays in your treatment.

AFTER HOUR EMERGENCIES

A recording is provided when you call the office after business hours. The message will detail how to reach the doctor on call.

The above information is intended to provide clarification and prevent future misunderstanding. I have read the above and understand the office policies of this office and agree to pay the fees established by this office or by my dental benefit plan.

_____	_____	_____
Patient Signature	**Printed Name**	**Date**