OFFICE POLICIES

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay direct to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

MISSED APPOINTMENT FEE

All patients are seen on an appointment basis. This permits us to schedule our day and to devote the proper amount of time to each individual as the situation dictates. We try to see all patients on time, and request you extend the same courtesy to us. If you cannot keep and appointment, please call us immediately. We require a 24-hour notice so that we may give this time to another patient. **If you miss a scheduled appointment without the courtesy of the 24-hour notification, a $50.00 per hour charge will be assessed.**

PAYMENT FOR SERVICES RENDERED

Payment is due at the time of service unless arranged in advance with the financial manager.

LATE CHARGES

If you do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. You realize that failure to keep this account current may result in your not being able to receive additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, you agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

I HAVE READ AND UNDERSTAND THESE OFFICE POLICIES

_____ _____

Signature of patient or parent if minor **Date**

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