

**OFFICE POLICY COMPLIANCE AGREEMENT**

Thank you for entrusting your dental care to our office. To make your experience the best possible, please thoroughly read our office policies listed below. Your signature at the bottom of the page is required and acknowledges your understanding of and agreement to comply with these policies.

**APPOINTMENT CANCELLATIONS & RESCHEDULING:**

If you are unable to keep your appointment, please call us immediately to cancel or to reschedule. This will allow us the opportunity to provide care for someone else. It is our policy to **charge $40.00 for any appointment that was not cancelled 48-hours in advance or for failing to show**.

It is our policy to dismiss patients from the practice and ask their insurance company to re-assign them a doctor if they miss three (3) or more appointments without a 48-hour notice.

**FINANCIAL:**

**Payment of ALL initial and emergency visits is due when services are rendered.** If you have dental insurance the financial coordinator will help you file for your reimbursement. For future appointments, **i**f you have insurance, the financial coordinator will calculate the estimated percentage your insurance is expected to pay, and your estimated portion will be collected at the time of treatment. **Any insurance payments that are received will be credited to your account, and any balance due will be billed to you.**

We accept Cash, Personal Checks, MasterCard, Visa, Discover, American Express, Debit Cards, and CareCredit.

In some instances, payment plans may be arranged with scheduled monthly payments. A credit history report may be obtained in this case, and financing is subject to approval.

For any treatment that requires laboratory services (i.e. crown, bridge, dentures, partials, and veneers), **a 50% down payment is required before the lab can begin to work on your case. The balance will be due before the item can be permanently placed unless a financial agreement has been arranged in advance.**

If a balance remains on an account **after 30 days**, regardless of insurance status, **a monthly finance charge of 1.5% (18% annually) will be assessed** **plus a billing fee of $5.00 per monthly statement.**

In the event of default, you are responsible for the payment of legal interest on the indebtedness, together with such collection costs, attorney fees and court costs as may be required to effect collection of this note.

**Failure to maintain your account current will result in payment for future services being collected prior to treatment being provided.**

The responsibility for payment for Dental Services provided in this office for yourself or your dependents is yours.

For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time of treatment.

**A fee of $30 will be assessed for returned checks.**

**INSURANCE:**

We ask that you bring your insurance card to all appointments. Please make sure that an address and phone number are listed so any claim can be sent promptly to the correct address and to ensure we have a way to contact the company should this become necessary.

Please inform us immediately of any changes with your insurance so we can update our records, as we are not responsible for any untimely insurance payments due to incorrect or lack of necessary information.

We are happy to complete any pretreatment information and send it to the insurance company as a courtesy.

Although we file claims for you as a courtesy, **at no time will the office enter into disputes with insurance carriers over delinquent or denied claims. The dental insurance policy is a contract between you, your employer and your insurance company, and it is your responsibility to contact the insurance company regarding delinquent payments.**

**Not all services are covered benefits in all contracts.** It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared, for whatever reason, by your carrier in 30 days, the unpaid portion will automatically become your responsibility and a statement will be issued to you for the unpaid portion. A monthly finance charge of 1.5% (18% annually) will be assessed plus a billing fee of $5.00 per monthly statement.

**Assignment of Insurance:** I hereby authorize the release of any information needed to secure the payment of benefits and authorize my insurance company to pay directly to this office (Robert E. Bell) benefits accruing to me under my policy. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance claim submissions.

**I HAVE READ THE OFFICE POLICY COMPLIANCE AGREEMENT. I UNDERSTAND AND AGREE TO COMPLY WITH THE OFFICE POLICIES.**

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 **PRINT NAME**

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 **SIGNATURE DATE**