

Dear Valued Patient:

Because your time is important to you, we will make every effort to begin your dental appointment on schedule. We, in turn, will depend on you to keep your scheduled appointment. We **require 48 hours notice** so that we may provide treatment for others. Appointments that are broken with less than 48 hours notice are subject to pre-payment in advance to secure the next appointment time.

I have read and understand the above appointment policy.

Signed _____ **Date** _____

Insurance

We view our patient relationships with a deep sense of responsibility. A major part of that responsibility is to help our patients understand and plan for their oral health and provide each patient the highest quality of dental care. Our practice is constantly updating our knowledge and techniques in order to ensure our commitment to quality care.

For decades, dental insurance has been an integral part of oral health planning, however, in the past few years it has become much more difficult for the dental practice to deal with insurance companies. We are a third party to the contract and the insurance companies are not obligated to share your confidential policy information with us or required to send payment to us. Also, there are constant changes being made with our coverage, deductibles, and annual maximums by your employer and the insurance company that are not being shared with us. Therefore, it is impossible for us to know exactly what your policy covers.

In order for us to maintain our high level of service to you the patient, we continue to provide the courtesy of submitting the claim on your behalf and supporting you with maximizing our benefits of your policy. However, we are no longer able to carry your insurance balance for longer than 30 days. Policy coverage changes and follow up on unpaid claims is your responsibility. We ask that if you have any questions about an unpaid claim or coverage that you immediately contact your insurance company directly as they will answer to you because you are the policyholder. You will receive a statement of account from our office that will indicate the status of your account and whether or not we have received payment from your carrier. Ultimately all fees for dental service rendered are your responsibility.

I have read and understand the office will carry my insurance balance for 30 days. It then becomes my financial responsibility.

Signed _____ **Date** _____

Five Year Guarantee:

The patient must continue to keep their regularly scheduled hygiene appointments in order for restorative work to be guaranteed due to breakage (not decay).

Signed _____ **Date** _____