



### **CANCELLATION and MISSED APPOINTMENT POLICY:**

We request 48 business hours notice to reschedule an appointment. We strive to provide the highest quality dental care for your child. This involves reserving the proper amount of time to dedicate to your child. We understand that situations occur that may prevent proper notice.

Additionally, after 1 cancellation without proper notice or missed appointments, one may be dismissed from the practice.

We apologize for such tough policies, but we are a small business and wish to set standards that make it possible to provide the highest quality of care.

### **FINANCIAL POLICY**

Payment for care is due at the time services are rendered. We accept cash, check and for your convenience MasterCard, Visa and American Express. With extensive treatment plans Care Credit and payment plans are available.

Please be aware that the parent bringing the child to our office is legally responsible for payment of all charges. We cannot send statements to other persons.

### **INSURANCE POLICY:**

We DO participate with a number of insurance plans. We will accept assignment of benefits for those plans we participate.

If we do not participate with your plan, we will submit the statement to the insurance company for you as a courtesy if your plan allows. Payment for the estimated portion of services is due the day of treatment.

Remember insurance plans do NOT cover the full cost of most procedures. We can attempt to estimate benefits prior to any treatment, but this is a courtesy and just an estimate. Ultimately the insurance company and the plan your employer selected will determine your reimbursement. The dentist is NOT a party to your insurance contract and has no control over reimbursements. Think of your dental insurance as a coupon towards each visit. We will do all we can to help maximize your benefits.

### **Past Due Accounts:**

Balances remaining unpaid at 30 days are subject to late payment charges of 1.5% per month, plus collection cost and attorney fees. Returned checks will be subject to a returned check fee.

**I agree to the above office policies:** \_\_\_\_\_ **Date** \_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE