Office Policies

We are happy you have chosen our office for your and/or family's dental care. It is our goal to provide you with the very best dental care and education in a friendly and comfortable environment. We understand the importance of excellent dental care and the positive impact a confidential and healthy mouth and smile can make in your life and the lives of your family and friends.
Our doctors are here for any specific needs you may have, as well as, to educate you and your family on good overall oral health and necessary dental treatment. Whether you require a routine dental exam, have tooth pain, or have questions about how you can have straighter, whiter, teeth-- we can help! To help make your dental treatment more affordable, we offer easy to use financial programs. These programs range from 3 to 12 months with no interest and no early pay off penalties. We understand that you may or may not need financing to pay for your patient portions, but it does open more doors if you are interested in full cosmetic reconstruction or if you have a monthly household budget.

CHILDREN and MINORS

If your child is scheduled for a dental appointment and is under the age of 18, a parent or guardian must be **present and in the office for the entire appointment**. If the parent or guardian leaves the office at anytime during the scheduled appointment, the office will stop all scheduled treatment until the parent or guardian returns and rescheduling may be required.

CANCELLATION POLICY

Your time is valuable and so are our Doctor's and staff's time. Therefore, we do REQUIRE that patients give 48 hours notice for all cancellations or rescheduling of dental appointments. If you fail to cancel or reschedule your appointment with proper notice, you will be charged a $25 missed, broken, or cancellation fee. For appointments that are over a total cost of $300.00, the charge is 10% of the total cost of the appointment. For Specialty appointments the charge is a minimum of $100.00. We understand that sometimes emergencies do come up with you and your family, so we will waive the late fee for certain circumstances. If you have questions, please do not hesitate to ask. The above statement will apply to frequent cancellations/broken/rescheduled appointments as well.

Signature:_____ Date:_____

Acknowledgment of our HIPPA/Privacy Law and Dental Restorative Material

By signing below, I acknowledge that I have been provided with a copy of the HIPPA Privacy Practice Law and have therefore been advised of how health information about me may be used and disclosed within our practices and how I may obtain access to and control this information.
By signing below, I acknowledge that I have received (or have been offered a copy) of the Dental Restorative Material Fact Sheet: The Risks and Benefits.
Signature:_____ Date:_____

Please list who you DO NOT want to have access to your pertinent medical information: _____
May we leave a message on your answering machine or with a person when trying to contact you? YES or NO

Refund Policy

In the event you choose to terminate treatment, there will be a charge of 10% for cash patients and 15% charge for credit card and care credit holders for processing fees. If given a discount for treatment plan and you pay in full and choose not to follow through with treatment, then the treatment that has been completed will be charged out at our UCR fee's. Patient refunds take 30 business days to process.

Signature:_____ Date:_____

For Patients Who Carry Dental Insurance

Please understand that all dental services provided to you and your family are charged directly to the patient. We will bill your insurance for services that are performed and carry the outstanding balance for you until the claim is paid as a courtesy. When we receive payment on your dental claim or claims, any unpaid portions by the insurance will become your responsibility and we will bill you accordingly. The other option we offer is that you can pay in full for your treatment and we can have your dental insurance company reimburse you directly for the services that they paid.

Please sign the option you would like below: (option 1 or 2)

1. I would like to pay my estimated patient portion at the time of service and understand that any residual balance that is left after payment is received by insurance will be billed to me by the dental office and will need to be paid within 30 days.

Signature:_____ Date:_____

2. I would like to pay for my dental services in full and have direct reimbursements from the dental insurance company sent to me.

Signature:_____ Date:_____

Our offices may close any insurance claim that goes for than 90 days without payment and you will be responsible for the balance on the claim and will have to contact you insurance company for reimbursement.

We would like to remind patients, that just because you have insurance, doesn't mean that it pays 100% of your fees. We will do our very best to answer any questions that you may have. Ultimately, it is the patient's responsibility to know how you policy works. All estimates to patients are just estimates. We do pride ourselves on our ability to provide you with an estimate of patient portions and insurance portions. These estimates that we provide are approximately 95% accurate.
Insurance is not a guarantee of payable benefits. A claim payment is determined once the insurance company has received a claim and it has been reviewed by your policy for eligibility based on frequency limitations, percentage of coverage, activation of policy at time of service, and overall dental consolation decision. Thank you!

Signature:_____ Date:_____