FAMILY DENTISTRY OF COLUMBUS OFFICE & FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy.

PAYMENT IS DUE PRIOR TO SERVICES (**EX: SRP/DEBRIDEMENT/PERIO MAINTANENCE) OR AT THE TIME SERVICE IS PROVIDED DEPENDING ON PROCEDURE TO BE SCHEDULED

We accept cash, personal checks, Visa, MasterCard, Discover, American Express and Care Credit. Returned checks will be subject to additional fees.

INSURANCE, DEDUCTIBLES, & CO-INSURANCES

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. Your dental insurance benefits were verified by our office according to information provided by you. The benefits quoted by your insurance company are just an estimate and are not a guarantee of payment**.** As a courtesy to you, we will help you process all your insurance claims. We ask that you pay the deductible & co-insurance, which is the estimated amount not covered by your insurance company, at the time we provide service to you and in some cases prior to services being rendered (Our office does require deductibles, co-insurances, or full payment be collected prior to scheduling such appointments as Periodontics and or any appointment(s) for patients that habitually miss/reschedule/cancel appointments). We must emphasize that what our office gives is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

INITIAL______ DATE_______

PARENT OR LEGAL GUARDIAN OF A MINOR PATIENT:

According to Law, a minor(s) is defined as any patient who has not reached the age of eighteen (18). Until age eighteen (18), a child, by law, remains under the care and control of his or her parent(s) or legal guardian(s). Thus, the parent(s) or legal guardian(s) who bring the minor patient(s) in for a dental appointment(s) is responsible for payment of services rendered on the day service(s) is/are provided. We can provide a dental treatment cost estimate prior to the scheduled dental appointment upon request.

INITIAL _______ DATE________

ALL PATIENTS

Must provide an ID Card & Insurance Card (if applicable) to be copied at the time of the appointment. We also require home and work telephone numbers, as well as a contact number to use in case of emergency.

OVER

APPOINTMENT POLICY:

Your appointment time is reserved for you. We will make every effort to remind patients by telephone prior to the appointment, but please do not depend on this courtesy. If we are unable to contact you directly, your appointment card or appointment phone call will serve as confirmation of your appointment and it implies your obligation to be present. Our answering machine is available for messages left after business hours, however if a message is left after business hours canceling or rescheduling a next day appointment the patient will be subject to our fee, as this is not considered adequate notice to fill the cancelled/rescheduled slot. We understand that extreme or unavoidable emergencies or circumstances do arise (ex. death in family, hospitalization), which may require you to cancel your appointment, and individual circumstances will be taken into consideration. If a patient thinks for any reason there may be a possibility when they schedule an appointment to which they may not be able to keep (ex. scheduled appointment but still out of town, financial reasons), our office would prefer that the patient wait to schedule when the time is right for them. This will help avoid any fees that can be applied to the account and keep slots open for patients that may be on a waiting list to be seen. We reserve the right to charge for any appointment(s) broken without a 24 hours notice. The charge will be a minimum of $35.00 per broken appointment(s) (this charge is subject to increase depending on the length and detail of the appointment that is scheduled). If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, we do ask that the patient call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. Habitual missed/cancelled/rescheduled appointments may result in a patient being required to either pay up front prior to scheduling an appointment or this office may no longer be available to provide dental services for the patient.

INITIAL______ DATE_________

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

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Print Name (Patient or responsible party)

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Signature (Patient or responsible party) Date