WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. Please take a moment to review our office procedures. If you have any questions regarding our Billing, Cancellation Policies, or Collections, please ask us - we will be happy to help.

ACKNOWLEDGMENT AND RELEASE:

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. As a courtesy we do prepare and submit forms and reports to assist you in obtaining maximum benefits available through your dental insurance plan. However, the dentist's treatment recommendations are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires, not available dental benefits.

Collection

I understand that my insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.
If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in being unable to receive additional dental services. In the event the balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. In the case of default on payment of the account, I agree to pay collections costs and reasonable attorney fees incurred in attempting to collect any outstanding account balances.

For your convenience we may keep a credit card on file for your family account for any charges that are determined to be the patients responsibility. This will prevent you from receiving billing statement or having late fees assessed to your account. Providing your account information below allows Great Smiles Dental Center to charge your credit card for the outstanding fees.

Credit Type: Visa / MC / Discover / CareCredit Acct#:_____ Exp Date:_____

CANCELLATIONS / FAILED APPOINTMENTS

We ask for at least 48 hours advance notice for canceling or rescheduling an appointment; otherwise a $50 fee may be assessed to your account. ***Note:*** *All cancellation/failed appointment fees must be paid prior to scheduling another appointment.*
The treatment that is planned for you is specific to you and it is important for you to keep the scheduled appointments to properly complete your treatment.
A broken appointment is a loss to multiple people:

- the patient who missed the valuable time
- the patient who could have taken the valuable time
- the doctor who was fully staffed and prepared for the appointment

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or dependents during the period of such dental care to third party payors or other health practitioners.
I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

_____ _____ _____

Print Name **Signature of Responsible Party** **Date**