

OFFICE POLICY

Welcome to Signature Dentistry. Our interest is to provide our patients with the finest possible dental care. As your provider, we advise treatment that is in the best interest of your medical and dental health. Be aware, often, insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs. Following is an overview of our office financial policy we provide to you as a courtesy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. As a courtesy, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement. **Initials** _____

Insurance Payments: Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a thirty (30) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial down payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays. **Initials** _____

Copyright: Any comment posted online in any way relating to Signature Dentistry, doctors or employees will be the sole right and property of Signature Dentistry and the copyright of the content of the comment, rating, or review is hereby assigned to Signature Dentistry to utilize at our discretion in order to protect the practice and our patient's anonymity and privacy. We appreciate public praise and comments and reviews. **Initials** _____

Payment: Payment in full is required at the time of service for patients without insurance. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard, and Discover. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through CareCredit. **Initials** _____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances are not apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed, as necessary. **Initials** _____

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in Signature Dentistry being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or \$30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees, and court costs. **Initials** _____

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48 hour notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of \$75.00 per hour. **Initials** _____

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Signature Dentistry.

I have read, understand, and agree to the above.

Signature of Person Responsible for Account

Printed Name of Person Responsible for Account

Date

(OVER)->