NORTHSIDE
DENTAL CLINIC

FINANCIAL POLICIES AND MISSED APPOINTMENT POLICIES

IF YOU HAVE DENTAL INSURANCE, PLEASE CALL US WITH THIS INFORMATION BEFORE YOUR APPOINTMENT.

In order to enhance communication and promote understanding regarding this office's financial and missed appointment policy, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please speak to the office manager. Thank you.

INSURANCE: We are happy to bill your primary insurance carrier as a courtesy for our patients. Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.

1. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts.
2. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to help speed things up.
3. If the insurance company does not pay in full within 60 days, we will require you to pay the balance due with cash, personal check, MasterCard, Discover, American Express or Visa.
4. We will do our best to estimate insurance coverage and patient portions due. We will send pre-estimates for services over $500 at your request. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment is expected within 30 days after the statement date.

PATIENT PAYMENT: Payment is due at the time services are rendered. We accept cash, checks, and all major credit cards. We also offer CARE CREDIT as an option. Returned checks will have an additional fee of $25.00 added to the amount of the returned check. Please contact the office manager for more information on any of the above payment options.

NO SHOW/MISSED APPOINTMENTMENTS: We request notice of 24 hours for cancellation of appointments. If appropriate notice is not given, a charge of $50 may be assessed to the patient's account. For appointments longer than 1 hour, the charge will increase, i.e., $75.00 for a two hour appointment, $100.00 for a 3 hour appointment. We understand that sometimes last minute cancellations are unavoidable. Individual circumstances may be discussed with the office manager and/or the dentist.

REFUNDS FOR UNFINISHED TREATMENT: Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or the dentist.

CREDITS ON AN ACCOUNT: If an insurance company pays more than anticipated, creating a credit for the patient, we are happy to either refund the patient or leave a credit on the account to be applied towards future treatment.

Date: _____

Printed name: _____

Patient/Guarantor Signature: _____