OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for choosing All about Smile Dental Group for your oral health care needs. Our team's expertise and commitment to our patients ensures you will receive the best comprehensive care possible. We hope to develop a professional relationship that will strengthen for years to come. In order to successfully maintain this relationship it is important to have a clear understanding of our policies.

INSURANCE

We must emphasize that as a dental health care provider, our relationship is with our patient, not the insurance companies. We are not part of your contract and cannot guarantee payments of all claims if only a portion of services are paid, or rejected in full an explanation will be provided to you by your insurance carrier. Reduction or rejection of your claim by insurance does not relieve the patient of their financial obligation to the office. We are not responsible for how HMO or PPO insurance claims are processed and paid out. For this reason we can only provide you with an ESTIMATION OF YOUR INSURANCE COVERAGE AND BENEFITS." Patients with insurance are required by contract to pay all co payments and deductibles at the time of visit, we do not balance bill payments owed to the office. For your convenience we accept Visa, Master card, discover American express, checks, and cash payments. We also offer special financing option with convenient monthly payments available to you with Care Credit and Wells Fargo.

FINANCIAL REQUIREMENTS AND PAYMENTS

We will carry an outstanding balance for 90 days or 3 consecutive billing cycles before an account is considered delinquent. We can offer a courtesy adjustment for our non insured patients for treatment that is paid in full, details upon request. There will be a returned check fee of $25.00 for any sufficient fund received by the office. This fee will be added to the patients account.

NOTICE OF PRIVACY PRACTICES

Your confidential information may be used to contact you (by phone, text, mail or email) to provide you with dental related correspondence. We may release information to anyone who is directly involved in your care, with written permission only. Your personal information will not be sold to any outside agencies. It may be disclosed to your insurance company or to government agencies as provided by law.

CHILDREN IN THE DENTAL OFFICE

As dental care providers, we have ever increasing safety regulations to abide by. Please do not bring children with you to the dental office unless they have an appointment or you have additional supervision with you at the time of your appointment, unfortunately, we cannot allow children inside the dental operatory while a patient is in treatment, nor we can allow children to be left unattended in the waiting area. These rules are for your child's well being as well as a courtesy to patients waiting for their dental appointments. We thank you for your cooperation and understanding.

CANCELLATIONS

A specific time is reserved when you schedule your appointment with one of our doctors or Hygienists. We require our patients to cancel appointments with a full 24 hour notice so we may offer this availability to patients waiting to schedule with the office. We will waive the first broken appointment fee as courtesy. Any cancellations made after initial write off has been accessed, a broken appointment fee will be applied to each patients account for any appointment that has been scheduled in and cancelled with less than a full 24 hour notice. It is our policy to charge a fee of $50.00 for cancellations made with our General dentist, or hygienists. A broken appointment fee of $75.00 for cancellations made with any of our specialists dentists. Cancellations of appointments made the same day must be done with at least an hour of notice or the broken appointment fee will apply. If our office is closed and you are requesting to cancel an upcoming appointment, please leave a message and we will notate your account. No fees will be applied for messages left before the required 24 hour notice.

By signing this agreement, I acknowledge and understand the office policies explained above pertaining to All About Smile Dental Group.

Name of Responsible Party (PRINT): _____

Signature: _____ **Date:** _____