# Caring Smile Family Dentistry Office Policies

- **Payment is required at the time of service.** Payment is required at the time of service. This policy applies to applicable and estimated deductibles and co-payments under your insurance policy. If you do not have dental insurance, we require full payment at the time of service. We accept cash, personal check, Visa, Master card, Discover, American Express, and Care Credit. There is a $25 fee for returned checks. If you need to make special payment arrangements, please discuss these prior to seeing the doctor. We will do our best to help find a satisfactory arrangement. **Initials_____**

- **Missed Appointments/ Last minute cancellations.** Please consider your scheduled appointments carefully. We require 48 business hours if you need to cancel or change an appointment. There *will* be a $25 fee applied to your account if less than 48 business hours' notice is given. If your appointment is scheduled for a dental procedure a $50 fee per hour scheduled will be applied to your account. **Initials _____**

- **Policy for handling Insurance**. Our office participates with many PPO dental insurance plans. Because each plan is different, we may not have all the details of your insurance benefits. Some questions are best answered by a representative of your insurance company. We will do our best to estimate your insurance benefits, however, amounts not paid by your plan become your responsibility. **Initials _____**

- **Collection Agency**. Patients with an outstanding balance of more than 90 days must make arrangements for payment, if arrangements are not made and the account balance is over 120 days, the account may be turned over to a collection agency. **Initials _____**

- **If the patient is a minor.** A parent or legal guardian accompanying the minor is responsible for the payment of the patient's account regardless of who holds the insurance policy. We require that all minors be accompanied by a parent or legal guardian for the initial visit. Following the first visit we may see minors without a parent or guardian if the parent or guardian provides written consent. **Initials_____**

## I understand and agree to these policies.

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**Patient Signature or Parent if patient is a minor** **Date**