OFFICE POLICIES

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our office policies which we require that you read, agree to and sign prior to any treatment. In order to provide the highest quality of care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these alternatives for payment. *Please CIRCLE the appropriate option:*

- We are happy to accept cash, check, and all major credit cards at the time of service. Unfortunately, we can not accept checks from new patients on the first visit.

- If you have insurance you will need to pay a YOUR ESTIMATED PORTION of the cost of your visit at the time of treatment. If you receive the check from the insurance company you will need to pay the entire balance due at the time of the service. We will as a courtesy, process your insurance benefits in our office which will relieve you of the time consuming and sometimes, complicated task.

- We do offer an extended payment plan with prior credit approval with Care Credit a GE company. If you need to fill out this form please ask for it prior to any treatment.

REGARDING INSURANCE
We do accept assignment of insurance benefits. We do however require your portion of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. You are responsible for information given to us as being current and correct. We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you, your employer and your insurance company. We are not a third party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan with CARE CREDIT or provide a CREDIT CARD NUMBER with AUTHORIZATION to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to your credit card or your care credit account. Please be aware some and perhaps all of the services provided may be "non-covered" or an exclusion of service in your policy and not considered under your DENTAL PROGRAM.

UCR (USUAL AND CUSTOMARY RATES)
Our Practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for paying the bill in full regardless of the insurance company's determination of usual and customary rates.

PATIENTS WITHOUT INSURANCE
Uninsured patients are responsible for full payment at time of service, unless prior arrangements are made with care-credit.

DISCOUNTS
We offer a 5% senior citizen discount to patients over the age of 65 PAID WITH CASH OR CHECK (NO CREDIT CARDS). Since we have a policy of no checks from new patients, we will only allow the senior citizen discount to patients that pay with cash on the first visit. A 5% discount will be offered to all patients who pay at the time of service with cash as a gift from Dr Davis.

MINORS
The adult accompanying a minor as the parents (or guardians) are RESPONSIBILE FOR FULL PAYMENT AT VISIT for the unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to any approved credit plan, Visa/MasterCard or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS
Unless canceled at least 24 hours in advance, our policy is to CHARGE FOR MISSED APPOINTMENTS at the rate of normal visit. ($100 per hour) Please help us serve you better by keeping scheduled appointments or canceling with enough notice so we may serve others who are waiting for our needed Dental Services.

Thank you for understanding our OFFICE POLICIES. Please let us know if you have any Questions or concerns.

I have read, understand and agree to the office Policies.

Patient or Responsible Party_____ **Date**_____

Co-Responsible Party_____ **Date**_____