POLICY CONSENT FORM

Appointment Policy:

You have scheduled your time to come here for your dental health and we promise to make every effort possible to meet your expectations.

We also have to schedule our time to best serve our patients. We will make every effort to confirm your appointment with you 2 days before your scheduled time. It is the *patient's* responsibility to notify the office 48 hours in advance of a conflict or need to change your scheduled time. If we do not receive this notification (during regular business hours), or if you fail to come when scheduled, it will be considered a failed appointment. If this occurs repeatedly you will be indicating to us that it may be better for you to seek your dental care elsewhere and we have the right to refuse to schedule future appointments with our dental care team.

We do understand that emergencies happen, (flat tire, illness, funeral) but we expect you to contact us when these things occur immediately.

Financial Policy:

We do expect payments on the *same day of service.*
A **5% discount** will be applied for payments made by cash or check on the *same day of service* for any non-insured patients. We do accept credit cards but no discount is applied due to a processing fee.

We have contracted with **Care Credit** to offer you a choice of payment options, including 0% interest plans for 6 months depending on the amount you need to finance. We are ready to answer any questions and assist you in the application process.

If you have third party payment benefits (dental insurance), you are encouraged to know the extent of coverage and limitations of your policy. It is the *patient's* responsibility to supply all necessary information so we can file claims (at no charge to you) with the carrier. You will be expected to pay any known deductibles or co-pays *at the time of your appointment*. By signing consent today, you are giving us permission to have your insurance company reimburse Beers Family Dental for any services that are completed. You will then be billed for any remaining balances after the claim has been processed. If you have any questions about your insurance please call. Regardless of the third party payment, benefits, the *patient* is always ultimately responsible for payment of services. We reserve the right to refuse to provide care to parties with outstanding debt.

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Signature of Patient or Responsible Party **Date**