COSMETIC & FAMILY DENTISTRY, P.C.
FINANCIAL POLICY

Thank you for choosing our office for your dental care. A clear understanding of our financial policy is important to our professional relationship. Compliance with our Financial Policy will benefit both the patient and Cosmetic & Family Dentistry, P.C. by helping to keep treatment costs down. Please read this document carefully. We will be glad to answer any questions you may have.

I authorize Dr. J. Brad Palles and the staff of Cosmetic & Family Dentistry (hereafter C&FD) to perform all recommended and agreed upon treatment. I also authorize the use of anesthetics and other medications as needed and am fully aware that using anesthetic agents involves certain risks. I authorize Dr. J. Brad Palles and his staff to discuss my medical history and treatment plan with other medical professionals as needed. I further consent to HIV and Hepatitis blood testing and documentation in the event of a needle stick during my care.

MY RESPONSIBILITY FOR PAYMENT

Patients are responsible for payment for all services rendered at the time of treatment. A 1.5% MPR finance charge is automatically tabulated on accounts sixty (60) days or older in addition to a monthly $5.00 billing charge. Should my account become delinquent, I will assume all collection costs and legal fees. Unless specific arrangements are made with the Financial Department, any balance due over 90 days will be referred to an outside collection agency. Any additional charges they make to collect the past due amount (about 50%) will be added to my balance. C&FD accepts cash and Visa/Mastercard.

PATIENTS WITH INSURANCE

Insurance is a contract between me and my insurance company. C&FD is not a party to this contract in most cases. C&FD will not become involved in disputes between me and my insurance company regarding deductibles, co-payments, covered treatment, secondary insurance or "usual and customary" fees other than to supply factual information as necessary. All quotes given from the insurance companies are ALWAYS an estimate, never a guarantee of payment. By submitting this form I certify I am covered by my dental insurance and I will assign all benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand C&FD will try to utilize my insurance benefits to the best of their ability and according to my treatment plan for dental care, however I acknowledge it is my responsibility to understand my personal dental insurance plan and what it entails.

PLEASE READ :

MISSED APPOINTMENT FEES

I understand that C&FD will try to contact me one (1) - two (2) days before a scheduled appointment. I will make sure C&FD has a correct home/cell and work phone numbers for me in order to confirm my appointment. A message left on my answering machine or voice mail will be considered a confirmation of the scheduled appointment. If my plans change or an emergency arises, I will call C&FD immediately. C&FD can usually fill my appointment if given 48 hours notice, but a visit canceled on the day of my appointment or a "no show" appointment cannot be filled. I understand that an appointment is a reservation for Dr. Palles' time with me. I agree to a $25 per half-hour broken appointment fee. I understand this will be charged to my account for all broken appointments or appointments which were canceled with less than 48 hours advance notice to C&FD. I cannot be reappointed at C&FD until this charge is paid. In the event I miss two or more appointments in an 18 month period, C&FD will charge a non-refundable deposit of $50 per half-hour for future appointments. If I make my scheduled appointment, this deposit will be applied toward treatment fees. Otherwise, I forfeit this deposit unless I give 48 hours notice.

_____ Please initial. I, Patient, have read & understand missed appointment fees.

I have fully read and understand this Financial Policy. I have been given the opportunity to ask questions regarding this document.

X_____ _____
Responsible Party Signature Date

X_____ _____
Staff Member Signature Date