

Financial and Insurance Guidelines

For the convenience of our patients, the following office policy and financial agreement has been established for your review.

INSURANCE: Your dental benefits are based upon a contract made between you or your employer and an insurance company. **Depending on your dental needs, dental insurance benefit plans may not cover 100% of your dental care. If you have any questions regarding your dental insurance benefits please contact your employer or insurance company directly.**

We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.**

We require payment of your estimated portion at the time of treatment. We will bill your insurance to maximize your benefit. It may take several weeks to receive payment from your insurance company. Once final payment has been received a statement of the remaining balance, if any, will be sent to you. We request that payment be made in a timely manner to avoid late fees or collection activity. You are ultimately responsible for what your insurance will not provide: deductibles, co-insurance, and non-covered expenses.

EXCEPTION: Cosmetic dentistry is not a covered expense through dental benefits! Due to the specialty lab costs and time allowed for cosmetic treatment, you are responsible for payment at time of service, and pre-payment may be required to reserve an appointment time.

PAYMENT POLICIES: We accept Cash, Check, Visa, MasterCard, Discover, and American Express. We also accept CareCredit as payment. If approved CareCredit offers 6 months no interest financing on services over \$400. An application for CareCredit approval can be submitted in office and will have a response within just a few minutes.

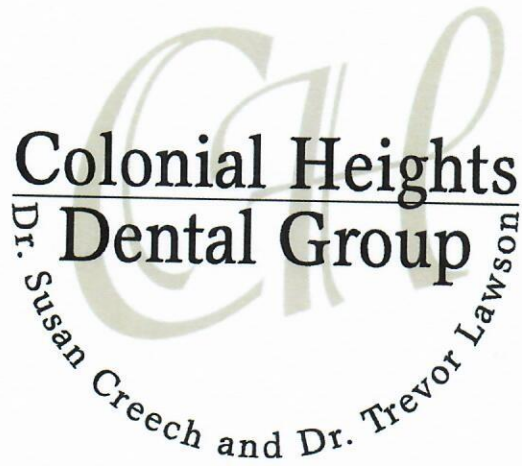
I, _____, understand and agree to the appointment and payment policies for Colonial Heights Dental Group. I authorize release of my dental/medical histories and other information about my dental treatment to third party payers.

Signature (Patient or Responsible Party)

Date

Office Representative

Date



Appointment Cancellation Policy

We strive to provide excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been reserved for you and when it is missed, that time cannot be used to treat another patient.

Our Policy is as follows:

We require that you give our office **24 hour** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of \$50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by our practice.

I, _____ (print name), have received a copy of Colonial Heights Dental Group Appointment Cancellation Policy.

Signature of Patient:

Date:
