

The Dentists on Jones Road

In the yellow house

Office and Financial Policies

Welcome to The Dentists on Jones Road and thank you for choosing us for your dental care. We are committed to providing you with the highest quality dental care, in an efficient, timely and cost effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

Initial ____ Insurance: When making an appointment with Dr. Rich or Dr. Dollens, it is your responsibility to confirm with your insurance company that we are currently under contract with your plan.

Initial ____ The patient is responsible for knowing their insurance benefit coverage. We will gladly file your insurance claim on your behalf. We allow 45 days from the date of a claim is filed for the insurance company to pay. If the insurance company does NOT pay within this time, you will be responsible for the entire balance. We will not be involved in disputes between you and your insurance company regarding coverage and or policy benefit criteria, deductibles, no-covered services, co-insurance, coordination of benefits, or reasonable and customary charges, etc other than to supply factual information when necessary. You will be asked to verify demographic and insurance information so that our records remain up-to-date.

Initial ____ Check-Out: Please be prepared to pay for the current visit as well as any past balances on your account. Payment of co-pays, deductibles or fees for non-covered services will be required at the time of service. For your convenience we take cash, checks, care credit and most major credit cards.

Initial ____ Late Arrivals: We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you will be rescheduled so that other patients are not inconvenienced.

Initial ____ No Shows and Late Cancellations: We require a 24-hour advanced notice if you must cancel your appointment. For your convenience, we will call to confirm your appointment. If you cancel on the same day as your appointment, you will be considered a **NO SHOW** without penalty. The second **NO SHOW** may result in a **\$25.00 charge to your account**. Once you have **two NO SHOW** appointments on your file, you may also be required to secure any subsequent appointments with a credit card and subsequent **NO SHOW appointment may be charged \$125.00**.

Initial ____ Minors: The parent or guardian accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have a written authorization for dental treatment signed by the parent or guardian before treatment can be rendered. **If you are sending your child to his or her dental appointment alone please send payment with the child. We are able to take the payment over the phone with a credit card.**

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filling and pre-certification by signing this statement.

Patient Name: _____ **DOB:** _____

Responsible Person's Signature: _____ **DATE:** _____