DENTAL ARTS CENTER

Jonathan E. Beaugez, D.M.D.

IMPLANTS.GENERAL.COSMETIC

STATEMENT OF OFFICE PROTOCOL

Patient Name: ____________________________________Birth Date: _____ _____ _____

Last First mm/dd/yyyy

Thank you for choosing our practice as your dental health care provider. Our practice is dedicated to quality care and exceptional service. We need your assistance and understanding of our appointment, insurance, and financial policies. Thank you for your cooperation in this matter.

APPOINTMENTS:

We respect the importance of your time and we work very hard to schedule appointments that accommodate the scheduling needs of all our patients. In return, we ask that patients make every comfort not to change their respective appointments. Broken, missed appointments create scheduling problems for other patients as well as the practice. We require a minimum of **48 hour notice** for any appointment changes so we may accommodate another patient. Iv less than **48 hour notice** is given, you will be charged a **$25/hour broken appointment fee.** Appointments are confirmed by mail and phone. If we are unable to reach you, we trust that you will keep your reserved appointment.

INSURANCE:

If you have dental insurance, as a courtesy to you, we will file your claims with your insurance company. We will try to research and answer any questions you may have about your insurance; however, we must emphasize that as a dental care provider, our relationship is with you – not your insurance company. **It is your responsibility to know your insurance policy and be familiar with your coverage.** If you have any questions regarding coverage, or payment of any claim, that we cannot answer, contact your insurance company immediately. If payment for services already rendered has not been paid in full within **45 days**, either by your or your insurance company, the remaining balance for treatment is considered due and collectible from the patient.

FINANCIAL:

Payment is due at the time services are rendered. This includes all estimated deductibles and co-payments. We accept cash, check, and all major credit cards. We also offer Care Credit, a dedicated credit card for health services with convenient monthly payments (O.A.C.). If you have flex/health savings reimbursement program through your employer, we will be happy to provide you, upon payment in full for your account, with whatever documents are needed for you to obtain direct reimbursement. Accounts with balance over **90 days** are considered delinquent and may be turned over to a third party collection service.

By checking here ☐ and signing below, I acknowledge that I understand and agree regardless of my insurance, I am ultimately responsible for the balance on my account for any professional services received. I have read the above information and agree to the above stated policy.

___________________________________ ______________________________

Signature (Patient's Guardian of Minor) **Date**