INTOWN DENTAL CENTER
QUALITY CARE YOUR FAMILY CAN TRUST

INTOWN DENTAL CENTER OFFICE POLICY / CONSENT FOR SERVICE

At Intown Dental Center, we are committed to providing you with optimum care that you deserve. We believe that your time is valuable and will make every effort to see you at your reserved time. We will also customize your treatment options and schedule you efficiently to maximize your time with us. We trust that you will honor your reserved time and financial responsibility to us.

INSURANCE:

We accept all primary dental insurance plans that allow you to choose your own provider. As a service to our patients we will prepare and submit your insurance claim form and accept payments directly from the insurance company if applicable. At the time of your appointment you will be expected to pay your deductible as well as any estimated portion of the treatment fee that are not covered by your insurance policy.

Changes in your treatment plan, insurance company downgrades and decisions by your insurance company's policies and practices on how they determine a covered benefit, can change the estimated treatment calculations presented by us. **Please be aware that our estimate for your treatment is only that: an estimate. There may be a balance on your account after we receive final payment from the insurance company, for which you are responsible.**

Our office will submit your claim to your insurance company **twice if necessary**. Additional submissions are the patient's responsibility. If your insurance company has not paid the full balance of the claim within 60 days of treatment date, you will be responsible for paying the balance.

APPOINTMENT POLICY:

We would like to thank you for choosing to be a patient in our office. We value all of our patients and strive to provide the best dental care possible in the most comfortable setting. We know that your time is valuable and we aim to honor your appointment time. If any of our patients need to be accommodated for an emergency, we will do our best to notify you of any delays in your treatment time.

We realize that illness, emergencies, and changes in work or school schedules occasionally occur. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly as that if you must change an appointment, please give us at least **24 hour** notice for every hour of appointment time reserved for you. This courtesy makes it possible to give your reserved time to another patient who would like it.

Our office does ask patients to confirm their appointments. We have many different ways that your appointment can be confirmed, including phone calls, email and texts. Please let us know your preferred method of communication with us.

BROKEN APPOINTMENT FEES:

It is our policy to assess a broken appointment fee. It is $**55.00/hr** for a broken appointment with the Hygienist and **$100.00/hr** with the Doctor per hour of appointment reserved. For example, if you were scheduled an hour with the hygienist and an hour with the doctor on the same day, you will be assessed **$155.00** for the broken appointment. A broken appointment is when you cancel or reschedule an appointment with less than **24 hours'** notice or you do not show up for the scheduled appointment. We require **48 hours**' notice if several members of your family were scheduled together for that day. Repeated broken appointments will result in non-refundable deposit to secure a future appointment time.

PAYMENT AND COLLECTIONS POLICIES:

Unless prior arrangements have been made, we expect payment at the time of service. A finance charge of 1.5% per month may be assessed to accounts with balances outstanding for 60 days from treatment date. This **FINANCE CHARGE** represents the **ANNUAL PERCENTAGE RATE OF 18%**. In the event of non-payment, the patient or responsible party agrees to pay all the cost of collection including but not limited to attorney fees, court cost, collection fees, etc.

If your check is dishonored or returned for any reason, you expressly authorize our office to electronically debit your bank account the amount of the check, plus $35.00 processing fee. **Your use of a check for payment is your acceptance of this agreement and its terms.**

By signing the signature sheet:

- I have read and understand that I am personally responsible for the payment on this account.
- I understand that I am responsible for any service deemed "not covered" by my insurance company.
- I authorize the release of any dental information to process my dental claims.
- I authorize payment of dental benefits to the named provider for professional services rendered.

PLEASE SIGN BELOW