

Financial Arrangements and Office Policy

For All Patients:

A payment for a service is expected at the time the service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash, personal checks, Visa, MasterCard, and Discover are all accepted. If an extended payment plan is desired, please ask us about our third party billing (finance) program. A 3% senior citizen discount is also offered, but cannot be combined with any other discounted offers. All unpaid accounts will be assessed a 1.5 % monthly finance charge after 60 days. Delinquent accounts over 90 days could be referred to a collection agency. All fees incurred from the collection agency will be charged to the account. If legal action is necessary then all fees are the responsibility of the patient.

For Patients with Dental Insurance:

We accept almost all dental insurance. As a complementary service we will file your treatment plan with your insurance company. We will estimate your deductible and the portion not covered by your insurance. Our estimates may differ somewhat from your insurance company's calculations; therefore the amount due our office may be adjusted accordingly. All procedures that are not covered by insurance are ultimately the patient's responsibility.

Office Policy:

If the need to cancel a scheduled appointment arises, we request 48 hours notification. Appointments cancelled within 48 hours or "No-Show" appointments will result in a \$50 per hour fee charged to your account. Please note that two (2) 'no-shows' can result in dismissal.

Finance charges: Balances over 60 days may be charged a finance charge of 2% compounded monthly until the balance is paid in full, unless other prior arrangements have been made with the office.

Patient Privacy:

Our practice is committed to securing the privacy of your health information. Accordingly, we have provided you with a copy of our practice's **Notice of Privacy Practices**. You are not required to read this notice. However, we would like your acknowledgement that you received this **Notice of Privacy Practices**.

Cell Phones: Please turn off all cell phones prior to entering the treatment area. Again, interruptions of dentist and assistant can affect the quality of treatment.

Signature _____

Date _____

Print Name _____

Our Promise:

Thank you for choosing our office as your oral health care provider. We are a "patient-centered" dental office and provide comprehensive, modern dental care to our patients. We strive to maintain our standards through patient service, professionalism, compassion, efficiency, and continuing education. Every staff member takes pride in achieving high standards in dental excellence and values forming lasting relationships with our patients. We are honored to have you as our patient and will make every effort to exceed your expectations.

Cozy Dental Group