Office Policies and Financial Agreement

Thank you for putting your trust in Darnestown Smiles LLC. Your oral health is our primary concern, and we are committed to providing our patients the best care possible in a comfortable and caring environment.

1) NO SHOW, MISSED APPOINTMENT OFFICE POLICY

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you provide us with at least twenty- four business hours' notice. This courtesy allows us sufficient time to notify another patient needing our care that an appointment time has come available. If we are not available to speak with you directly, we do have a 24-hour voice message system/e-mail that you can leave a message regarding changing your appointment.

***There is a charge of $50.00 for not showing up for scheduled appointments and last-minute cancellations.**

***If two or more appointments are missed or cancelled without sufficient notice, we reserve the right to inactivate your family as patients in our office.**

When your appointment is made, a time is reserved, your materials are ordered and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient or unexpected difficulties occur; you can expect us to be prompt. We, of course, would appreciate the same courtesy from you. We understand things happen unexpectedly, but we ask for your assistance in this regard.

2) PATIENT TREATMENT CONSENT AND FINANCIAL AGREEMENT

I authorize Darnestown Smiles to perform such aids deemed appropriate to make a diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the dentist and mutually agreed upon me.

If your plan provides benefits for services in our office, you will be asked to leave the anticipated co-pay at each visit. **THIS IS ONLY AN ESTIMATE.** We will file insurance claims and submit the information necessary for your insurance company to process those claims. This is a service we provide as a courtesy to our patients, but please understand you have the contract with the insurance company and ultimately are responsible for payment. We will not guarantee a payment will be made from your insurance company, nor will be make a settlement on a disputed claim.

Our practice is committed to providing the best treatment possible to our patients. You are responsible for the cost of treatment provided regardless of an insurance company’s arbitrary determination of the “allowable” fees.

Remember, you are the holder of the contract. It is your responsibility to ensure you understand the contract between you and your insurance company and to know the benefits available under your policy. If after 60 days your insurance company has not rendered payment the balance will become your responsibility.

I assign all dental insurance benefits to the extent permitted under my dental insurance policy to this practice. I agree and allow the provider to submit insurance forms and receive payment directly from the insurance carrier with notation "signature on file." I authorize my dentist to release treatment record/x-rays or any information deemed pertinent to my insurance carrier as necessary and/or requested.

I agree to pay for all services rendered on my behalf or my dependents at the time of service. I agree that my unpaid claims that the carrier does not pay or any balance that extends beyond 60 days from the date of service will be assessed a service charge of $20.00 late fee per month. In an event that this balance should be submitted to collections, there will be a fee of $100.00 charged to the account balance. If these fees should be added to your account, you will be notified by mail.

3) MINORS

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will not be performed, unless prior payment has been made or charges have been authorized by the parent or legal guardian to a valid credit card accepted by our office.

4) SIGNATURE RELEASE

I authorize the releases of dental/medical information necessary to either process my insurance claims for treatment performed by Darnestown Smiles, LLC, or when necessary, to other providers rendering medical/dental care. I assign all dental/medical/surgical benefits for treatment performed by Darnestown Smiles to which I am entitled to be paid to Darnestown Smiles, LLC. This assignment will remain in effect until revoked by me **in writing**. A copy of this assignment is to be considered as valid as the original.

PATIENT'S SIGNATURE _____

(PARENT IF MINOR)

DATE _____

PATIENT'S NAME (PRINT PLEASE) _____

****All patients are required to sign an updated financial agreement every year****