Patient Agreement

Insurance& Self-Pay Information

As a courtesy, Warrenton Family Dentistry will assist in processing your insurance claims. For us to file your claim, you must provide proof of insurance—either by presenting your insurance card or completing the necessary information on the first page of our New Patient Packet.

Please note that all charges incurred are ultimately the patient's responsibility, regardless of insurance coverage.

I, _____, authorize Warrenton Family Dentistry to receive payment directly for services rendered, whether from insurance benefits **or** personal payment. I also authorize the release of any necessary information required to process claims and secure payment. This authorization applies to all payment types and insurance submissions, whether manual or electronic. I confirm that I am the patient or a legally authorized individual responsible for the patient's care and financial obligations.

Important Notice Regarding Claims:
Claim denials will not be resubmitted by our office. We will abide by the insurance company's final determination. Any unpaid balance becomes the patient's responsibility. If you wish to appeal a denied claim, the appeal process must be initiated and handled by you directly with your insurance provider.

Radiographic (X-ray) Requirements

As part of our standard of care:

- Adults: Annual radiographs are required
- Children (Ages 6–12): Radiographs are required twice per year

This may include:

- Bitewing X-rays (2 sets): Detect decay between teeth and monitor bone levels
- Full-Mouth X-rays (1): Assess the full tooth structure and supporting bone
- Periapical X-rays (2): Evaluate specific teeth as needed
- Panoramic X-ray (1): Provide a comprehensive view of all teeth, jaw joints, and bone structure

Patient Initials: _____

Payment Policy

Our office policy is: **"Payment Due at Time of Scheduling."** Your estimated out-of-pocket cost (the portion not covered by insurance) is due when scheduling your appointment. This estimate may be adjusted based on final insurance processing after treatment. For patients without insurance, full payment is due at the time of scheduling.

Accepted Forms of Payment:

- Cash - Check - MasterCard - Visa - Discover - American Express - Care Credit

Credit Card Processing Fee

A 2% processing fee will be added to all credit card transactions. If a refund is issued to a credit card, the 2% fee will not be refunded.

Appointment Cancellation Policy

Cancellations made within **48 hours** of the scheduled appointment will incur a **$50.00 cancellation fee**. This notice allows us time to offer appointments to another patient in need.

- **Patients who accumulate three or more late cancellations or "No-Call, No-Show" appointments within a two-year period may be subject to dismissal from the practice.**

Zero Tolerance Policy

Warrenton Family Dentistry is committed to providing a respectful and safe environment for all patients and staff. We enforce a Zero Tolerance Policy regarding inappropriate behavior, including:

Verbal Abuse:
- Yelling, name-calling, offensive language, racial or discriminatory remarks

Physical Abuse:
- Pushing, hitting, spitting, or any form of physical assault

Threats:
- Verbal threats, stalking, or any action that creates fear or intimidation

Intimidation:
- Aggressive gestures or posturing intended to instill fear

Disruptive Conduct:
- Refusing to cooperate with staff, creating a hostile environment

Other Unacceptable Behaviors:
- Being under the influence of alcohol or illegal drugs, damaging property, refusing to leave the premises when requested

Consequences:

Any behavior deemed inappropriate will result in dismissal from the practice. A formal dismissal letter will be issued, and the individual and their family will no longer be welcome as patients at Warrenton Family Dentistry.

Patient Initials: _____

Acknowledgement and Agreement

By signing below, you acknowledge that you have read, understand, and agree to abide by the policies outlined above. We are committed to providing exceptional dental care and appreciate your cooperation.

Printed Name of Patient or Responsible Party: _____

Signature of Patient or Responsible Party: _____

Date: _____

Warrenton Family Dentistry

505 Ingram Lane

Warrenton, MO 63383

636-377-1233

Date: _____

Name: _____

Additional Family Members: _____

Due to the HIPAA regulations, I hereby authorize the following names of those listed below to discuss and participate in my medical care.
(Please write names of family members/friends who may be calling on your behalf; it is not necessary to list doctors' names.)

NAMES	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have read the Notice of Privacy Practices and Authorization (HIPAA). **I understand that if the names are not listed above, the office of Warrenton Family Dentistry cannot release any information.**

Signature: _____

Relationship to Patient: _____