OFFICE POLICY

Payments:
Payment for treatment is **due in full at time of service**. When scheduling treatment, half must be paid at time of scheduling appointment and the other half on day of or before services are rendered. Any special arrangements for payment must be made prior to treatment with your financial coordinator or office manager. **_______Initial**

Dental Insurance:
Our office files insurance claims as a courtesy to our patients. Employers offer dental benefits to help employees pay for a portion of the cost of their dental care. Dental plans are designed to share in the cost of your dental care, not to completely pay for those costs. The amount your plan pays is determined by your employer with the insurance carrier. Your dental coverage is determined not by your dental needs, but by how much your employer contributes to the plan. Our office can only estimate insurance coverage from information provided by your insurance carrier. Your insurance carrier makes the final payment determined on each claim for treatment. Any portion of co-payments and/or out of pocket expense must be paid for at the time of scheduling and time of dental services. **_______Initial**

Dental Warranty
Unfortunately there are times when dental treatment may fail. Because of this, we will warranty dental treatment that is paid in full. We will cover, in full, restorations for 2 years and all other treatment for 5 years, **only** if patients follow Associates of Dental Arts recommendation for treatment, home oral hygiene care and continuing care. All patients must maintain hygiene visits recommended by hygienists. **________Initial**

Cancelations, Reschedules and No Shows
Any cancelations or rescheduling should be done as soon as the patient becomes aware of any changes. Out of courtesy to our other patients and dental team, we request two full business day minimum notice. This policy allows our office to provide timely service to all our patients that need appointments. If a patient does not call to cancel or reschedule an appointment, or does not show, it is possible that the patient may or may not be eligible to reschedule for future appointments. **A $25 office fee per each missed hour will be charged.** Our office is open for business Monday through Thursday 7am to 5pm. **________Initial**

I assume the responsibility of updating any changes in my "Patient Information" and "Health History" forms at future visits. I consent to the dental treatment deemed necessary by Associates of Dental Arts with the understanding of a mutual agreement before treatment begins. Associates Dental Arts will assist in filing dental insurance when eligible, but I understand I am responsible for all cost of any collection fees, including reasonable attorney fees. I agree that Associates of Dental Arts, or any other collection or servicing agency retained by the facility to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call/text. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail address I provide to the facility or is otherwise associated with my account. **_______Initial**
I consent to Associates of Dental Arts taking photographs, videotape, and or digital recordings for marketing and training purposes.

We would like to notify you that we record all phone calls for training purposes.

Signature of patient or legal guardian: ________________________________Date:_____________