



HOURS: Monday through Friday 8:00 AM to 5:00 PM

APPOINTMENT POLICY: Our office considers all pre-appointed visits to be **confirmed**. We make every effort to verify your appointments at least 48 hours in advance. We offer courtesy reminders through automated phone calls, texts and emails, when applicable and an adequate cancellation notice for any change in your appointment time is necessary so that we can offer valuable doctor or hygiene time to another patient. We would greatly appreciate your letting us know as soon as possible if it becomes necessary for you to cancel or change your appointment time.

INSURED PATIENTS: If you have **Dental** insurance please provide us with the proper information preferably by telephone during our first conversation and please bring your insurance card and any other pertinent information. For your convenience, we will process your insurance claim the day of your visit. You are responsible for the timely payment of your account regardless of insurance coverage. It is our policy to collect your co-pay along with deductibles on the day of your treatment.

Insurance is a contract between you and your insurance company. We are not a party to this contract. Please be familiar with your policy regarding deductibles, co-payments, covered charges, secondary insurance carriers, etc. Legally we cannot become involved in any disputes, other than to provide factual information as necessary.

FINANCIAL POLICY: Payment is expected on the day of treatment.

For major work, if financial arrangements are needed they must be made prior to the start of treatment. We accept Visa, MasterCard, Discover, American Express, Personal Checks, Care Credit, and Cash.

***Any account with an outstanding balance for more than 60 days with no payment arrangements agreed upon will be charged a professional service fee of 1.5%. You will be responsible for any additional charges which may occur if the account is turned over to a collection agency. ***

***The undersigned understands and agrees to have a credit report done if credit arrangements are requested. You are allowed to have a free report done once a year.

AUTHORIZATION

I hereby authorize payment directly to Dentistry at Sugarloaf the dental insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and I understand that my dental insurance carrier may pay less than the actual bill for services. I hereby authorize Dentistry at Sugarloaf to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Patient Name

X _____
Signature of Responsible Party

Date _____