



SMITH & ROBINSON, DMD
GENERAL AND COSMETIC DENTISTRY

Office Policies

So that we may provide you with outstanding customer service and care, please review the following policies:

- X _____ • **Payment is due when services are rendered.** We accept cash, checks, Visa, Mastercard, and Discover. Additional financing is available pending approval through Care Credit.
- X _____ • **Insurance:** We accept assignment of most dental plans. However, we do require payment of the estimated co-payment portion of your bill at the time of service. After your dental plan process your claim, you will be responsible for any remaining balance. Your policy is a contract between you and the insurance company. If your dental plan has not paid your account in full within 45 days, the balance must be paid once you receive your statement. Please be aware that some, and perhaps all of the services provided may be non covered services and may not be considered reasonable and customary under your dental plan. Our practice is committed to providing excellent patient care and our charges are usual and customary for our area. You are responsible for payment regardless of a dental plan's arbitrary determination of usual and customary rates. Please be advised that if your treatment is not covered under your specific plan, full payment is due at the time of service.
- X _____ • **Adult/Minor Patients:** Adult patients are responsible for full payment of their estimated portion of fees at the time of service. The adult/parent/guardian accompanying a minor is responsible for payment at the time of service as well. Children under the age of 16 MUST be accompanied by a parent or guardian at all times. For unaccompanied minors, non emergency treatment will be denied unless charges have been prearranged.
- X _____ • **Missed Appointments:** We certainly understand that scheduling conflicts do occur. In order to prevent assessing a broken appointment fee of \$50.00, we require 1 business days notice for cancellations. This time is reserved exclusively for you and is not shared with others. Please help us help you by keeping your reserved time. We now require a \$100 deposit to appoint for any treatment over \$500. This deposit is to reserve your appointment and will be applied to your total cost when treatment is completed. You will not lose this deposit if you need to cancel as long as you give 1 business day notification. Only cancellations with less than 1 business days notification will forfeit your deposit.
- X _____ • **Billing Statements:** Statements are mailed once a month. We will also send you a statement when a payment is received from your dental plan to inform you of your remaining balance. Payment in full is expected on all statements, unless prior financial arrangements have been made.
- X _____ • **Interest:** We reserve the right to charge interest in the amount of 1 ½% (18% APR) as provided by state law.
- X _____ • **Returned Checks:** There is a \$25.00 charge for checks that are returned due to insufficient funds and payment will be immediately due in cash.
- X _____ • **Collection Fees:** For delinquent accounts that are sent to a collection agency, you agree to reimburse us the fees of that collection agency based on a percentage at a maximum of 32% of the debt, and all costs, and expenses, including reasonable attorneys' fees that we incur in such collection efforts.

I have read and understand the above policies and agree to all terms stated above.

Date:

X _____