FAMILY CARE DENTAL

THANK YOU FOR CHOOSING FAMILY CARE DENTAL, INC. WE ARE COMMITTED TO PROVIDING YOU WITH THE VERY BEST IN DENTAL CARE. IN ORDER TO BETTER SERVE YOU, PLEASE READ THROUGH THE FOLLOWING POLICIES AND FEEL FREE TO ADDRESS ANY OF YOUR CONCERN TO OUR FRIENDLY STAFF.

MISSED APPOINTMENTS

NO CHARGE WILL BE MADE FOR RESCHEDULING AN APPOINTMENT PROVIDED 24 HOURS NOTICE IS GIVEN. OTHERWISE, A MINIMUM CHARGE OF $25.00 PER HALF HOUR MISSED WILL BE INCURRED. ONCE AN APPOINTMENT HAS BEEN MADE, THAT TIME HAS BEEN RESERVED SPECIFICALLY FOR YOU AND YOUR DENTAL NEEDS. PLEASE KEEP THIS IN MIND WHEN SCHEDULING.

INITIALS_____

INSURANCE ASSIGNMENT

AS A COURTESY TO YOU WE WILL GLADLY PROCESS YOUR INSURANCE CLAIMS. PLEASE BE AWARE THAT YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, WE SIMPLY SUBMIT YOUR CLAIMS. AT THE TIME SERVICES ARE PROVIDED WE WILL GIVE YOU AN ESTIMATE OF YOUR INSURANCE BENEFITS BASED ON THE INFORMATION PROVIDED BY YOUR INSURANCE COMPANY. KEEP IN MIND THIS IS ONLY AN ESTIMATE, AND DEPENDING ON WHAT YOUR INSURANCE ACTUALLY PAYS, YOUR BALANCE MAY BE MORE OR LESS THAN WHAT WAS QUOTED. FOR YOUR FULL INSURANCE BENEFITS PLEASE REFER TO YOUR COVERAGE BOOKLET. ***IF YOUR INSURANCE DOES NOT COVER THE BALANCE AS ESTIMATED, THE REMAINING PORTION WILL BECOME YOUR RESPONSIBILITY AND IS DUE WHEN YOU ARE NOTIFIED.***

INITIALS_____

FINANCIAL CONSENT

THE PATIENT (GUARDIAN) AGREES TO BE FULLY RESPONSIBLE FOR THE TREATMENT PERFORMED IN THE OFFICE, REGARDLESS OF ANY ESTIMATES GIVEN OR INSURANCE PAYMENTS MADE. ANY COLLECTION COST INCURRED FOR THE ABOVE WILL BE MY RESPONSIBILITY. YOU AGREE TO REIMBURSE US THE FEES OF ANY COLLECTION AGENCY, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 33% OF THE DEBT, AND ALL COSTS, AND EXPENSES, INCLUDING ATTORNEYS' FEES, WE INCUR IN SUCH COLLECTION EFFORTS.

INITIALS_____

I CERTIFY I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE

PATIENT / GUARDIAN SIGNATURE_____ Date _____