Patterson Family Dentistry, P.C.

Office Policy

Your appointment time is reserved for YOU, and we make every effort to stay on time and to respect your time. Please help us to serve you and other patients better by notifying us if changes in your schedule occur. We require, at minimum, 24 business hours advanced notice of cancellation, but prefer 48 hours so that we have time to contact other patients wanting that appointment time. We reserve the right to charge a per hour failed appointment fee of at least $25.

A failed appointment is considering being 15 or more minutes late, cancelling less than 24 hours prior to appointment, or not showing at all. If a total of 3 appointments are failed within a 2 year period by you or your family, we reserve the right to inactivate both your chart, as well as immediate family. If this occurs, records can be sent to an office of your choice for a nominal fee to copy records and duplicate x-rays. We would also assist you in finding a new dentist.

We can only be as punctual as our patients. We appreciate your attention in this matter and thank you for helping us serve you and all of our patients better.

Insurance Policy

Our practice is a fee for service practice. We do **not** participate in any third party agreements (PPO, DMO, etc.). We **do** file your insurance claim for you, or we will provide you with all necessary claims filing information.

Various insurance plans cover from 0% to 100% of your dental costs. Remember that our services are rendered and **charged to the patient** and **not** to the insurance company. When payment is directed from your insurance company to Patterson Family Dentistry, P.C., **you are responsible for any amount not covered by your plan.** The patient is responsible for **all** charges to be paid in full within 60 days of treatment regardless of any pending insurance claims.

We will make every reasonable effort to collect from your insurance carrier. However, our office cannot be responsible for collecting your claim or negotiating a settlement on a disputed claim. Please direct any questions or complaints regarding your coverage to your insurance carrier and/or employer.

Remember, your insurance company or union has an obligation to you, **not to the doctor. You are financially responsible to us for the services rendered.** In the case of minor children, we do not get involved in the financial arrangements related to divorce settlements. **The parent or guardian initially presenting the child will be held responsible for all charges.**

Fee Payment & Billing

We want to give you the best and most reasonable service possible at a fair cost. In order to do so, we require payment in full at time of service unless prior arrangements are made. There will be a $30.00 fee for returned checks.

Accounts Past Due

All charges are due and payable within 60 days of treatment. You are responsible for payment of your account, even though an insurance claim may be pending.

If a financial situation makes it impossible for you to pay for all of your dental services within 60 days of treatment, please call and personally discuss the matter with us. We do not know you are having payment difficulties unless you tell us.

Accounts 90 days past due are referred to a collection agency, unless prior arrangements have been made with us.

Financial Agreement

I acknowledge that payment is due at the time of treatment unless prior arrangements are made. I agree parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all fees assessed and charges for services provided. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. If the fees pursuant to this agreement are not paid, I understand that the patient and responsible party(ies) shall be responsible to pay Patterson Family Dentistry, P.C., all costs of collection, including but not limited to reasonable attorney's fees and contingent fees up to fifty percent (50%) of amount collected which may be charged by an attorney.

Signature: ____ Date agreed to this document: ____________________

(Patient or Guardian/Presenting Parent of Minor)