Value Smiles

OFFICE POLICY

The best dental care is based on a friendly mutual understanding among staff, doctor, and patient. The doctor desires to provide superior service to our entire family of patients. In order to do this, we ask for your help on these areas. Thank you and welcome!

APPOINTMENTS

- We strive to see patients at their reserved time. However, we are a medical facility and occasionally circumstances arise that require us to spend more time with a patient. We will always give you the same care and understanding.
- Patients arriving 15 minutes late may be asked to reschedule as a courtesy to the following patients.
- Short notice cancellations hinder us from providing care to others. If you do find that you must reschedule, we require at least 48 hours notice. Please call the office and leave a message if you have to call after business hours to reschedule or cancel an appointment.
- We do reserve the right to charge **$40.00** for broken appointments. This time has been set aside for you and hinders us from treating other patients and their concerns.

RADIOGRAPHS/TREATMENT RECORDS

- The original x-rays and treatment records are the property of Value Smiles, if copies are needed there is a $20.00 charge for duplication of any x-rays and records. Please give our office a 5 day notice for x-ray or record duplication.

INSURANCE/PAYMENT POLICIES

- Our mission is to provide you with optimal dental care regardless of insurance coverage.
- At the onset of each visit, patients should be prepared to pay in full or for those with insurance, their deductible and estimated co-payment. Financial questions should be addressed prior to start of treatment.
- To patients with insurance:
    - We allow 45 days for insurance to pay its portion, and our office DOES NOT guarantee payment by your insurance company.
    - If your insurance claim is denied, or it is not paid as estimated, the balance will become the patient's responsibility.
- Accounts referred to our outside collection agency will be assessed an additional amount of 35% of the overdue balance.
- In the event any type of collection procedures become necessary, you will be responsible for any collection, legal, or attorney fees incurred for you or, if applicable, your dependents.

- **This office accepts Cash, Master Card, Visa, American Express, and Care Credit as methods of payments. <u>PERSONAL CHECKS WILL NOT BE ACCEPTED</u>.**

The undersigned hereby authorizes the doctor(s) and/or designated staff of Value Smiles, to perform whatever dental treatment, dental operation, diagnostic aids and test, or any other procedure deemed necessary or appropriate by the doctor(s) to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Value Smiles to perform all recommended treatment mutually agreed upon by me and employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I authorize my insurance benefits (if applicable) to be paid directly to Value Smiles and I authorize the release of any information required. I understand that Value Smiles will file my insurance claims (if applicable) as a service to me, but that I am responsible for all amounts not paid by the insurance company for any reason. Should my insurance company (ies) fail to pay within 45 days, for any reason, I will be expected to remit payment in full. I further understand that a finance charge of 18% will be added to any overdue balance. If collection and/or legal service are required to obtain payment of the amount billed, I further agree to pay for all legal costs reasonably incurred in connection therewith.

Signature:_____ Date:_____

Printed Legal Name:_____ Patients Name:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____Birthday_____

Signature_____

Date_____