## Office Financial Policy

Thank you for choosing our practice as your dental care provider. We are committed to providing our patients with the best dental care. Our goal is to provide high quality dentistry in a safe and cheerful environment. Our patients are the most important part of our practice. Please feel free to offer suggestions or discuss any questions or concerns you may have.

### Patient Responsibilities

- I understand I am responsible for all fees related to my dental care and treatment.
- **I understand that full payment and /or co-payment for all dental treatment is to be paid at the time treatment is performed, unless other arrangements have been made prior to appointment.**
- I understand that if a check, or other instrument, or any electronic authorization or debit sent or provided to the office for payment is not honored upon first presentment, regardless of the reason, I will be charged a $29.00 service charge.
- I understand that if my account is not timely paid on a monthly basis, my account may be turned over to a collection agency. In addition to paying my balance, I agree to pay all reasonable attorney's fees, collection and/or court costs, and a monthly interest charge at applicable maximum legal rate.
- **I understand that the charge for copies of x-rays and treatment information is currently $25.00. These fees are subject to change without notice.**

### BROKEN AND/OR MISSED APPOINTMENTS

**As a courtesy to our patients we confirm your appointment. The office reserves the right to charge a fee of $10.00 per each fifteen (15) minutes of your appointed time, without a twenty-four (24) cancellation notice. After three (3) broken or missed appointments, the dentist retains the right to discontinue elective treatment.**

### PATIENTS WITH DENTAL INSURANCE

Dr. Schamp is contracted with several dental care service plans that provide professional dental services. We will file to your insurance company as a courtesy. Authorization from your insurance does not always guarantee payment. The undersigned and/or patient shall remain responsible for all charges, applicable co-payments and deductible. **You are responsible for services that are not covered by your insurance company.**

- I understand that my insurance policy is a contract between myself and my insurance company. Dr. Schamp and her employees are not parties to my contract with my insurance company.
- I understand that I am responsible for any and all balances, even if my insurance company estimates to pay a balance and later does not pay.

### SELF PAY & NON-PARTICIPATING INSURANCE

All fees are due in full at time of service unless other arrangements have been made prior to appointment. A receipt is provided which details all dental services and payments for the office visit. A copy of the receipt can be submitted to your insurance carrier for direct payment to you, the policyholder.

**WE THANK YOU FOR YOUR UNDERSTANDING**

I have read, understand and agree to the above office policy.

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| Signature of Patient, Parent or Guardian | Print your name | Date |