

OFFICE POLICIES

1. TO AVOID A CANCELLATION FEE WE REQUIRE A 24-HOUR NOTICE WHEN CANCELLING OR RESCHEDULING AN APPOINTMENT.
2. WE ACCEPT MOST MAJOR INSURANCE CARRIERS AND MANY, BUT NOT ALL PPO'S.
3. PLEASE CONTACT YOUR INSURANCE CARRIER TO FULLY UNDERSTAND WHAT YOUR FINANCIAL RESPONSIBILITY WILL BE AFTER YOUR INSURANCE HAS PAID THE COVERED PORTION OF YOUR CHILDS' DENTAL BILL.
4. IF YOUR CHILD IS UNINSURED, PAYMENT IS DUE AT THE TIME OF SERVICE. FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND DEBITCARDS.
5. WE WILL BILL YOUR PRIMARY INSURANCE COMPANY FOR ALL NON-COSMETIC PROCEDURES. YOU ARE RESPONSIBLE FOR ANY BALANCE. PAYMENT IS DUE UPON RECEIPT OF THE STATEMENT.
6. IF YOUR INSURANCE REQUIRES A SOCIAL SECURITY NUMBER AND YOU DO NOT FURNISH IT, YOU WILL BE RESPONSIBLE FOR THE COST OF THE TREATMENT.
7. IT IS YOUR RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES, I.E. INSURANCE COMPANY, CONTACT INFORMATION AND HEALTH HISTORY.
8. RETURNED CHECKS FOR INSUFFICIENT FUNDS WILL INCUR A SERVICE FEE OF \$75.

PLEASE INITIAL AND DATE UPON RECEIPT _____ DATE _____