CANCELLATION/LATE POLICY and FINANCIAL POLICY STATEMENT

CANCELLATION/LATE POLICY:

Your appointment time is reserved especially for you and your care. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. We understand that unplanned issues can come up and you may need to cancel an appointment. If you need to cancel or reschedule your appointment, we request that you let us know at least twenty-four (24) hours in advance, so that we can make the time available to another patient.

Patients who have confirmed their appointment and cancel the day of or do not show for their scheduled appointment will be charged $100. If you cancel the day before your appointment and do not reschedule, you will be charged $50.00.

Patients who arrive for their appointments more than 15 minutes late may have to be rescheduled. If you need to be rescheduled because of being late, you may be charged a fee of $50.

Thank you for understanding and for being a valued patient.

I have read and understand Six Forks Family Dentistry's Cancellation Policy.

_____ PATIENT INITIALS

FINANCIAL POLICY STATEMENT:

We bill insurance carriers solely as a courtesy to you. You are responsible for the entire bill regardless if insurance is in effect or not. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If your insurance company requests a refund of payments, you will be responsible for the amount of money refunded to your insurance. It is your responsibility to know your insurance benefits and to provide us with the necessary and correct information to file your claim. If your insurance changes we must be notified of the change, and you must investigate with your carrier as to whether you will be able to have treatment in our office. There are numerous plans available under the same carrier and it is impossible to know the details of every plan. Every effort will be made to help you through this process, but it is ultimately your responsibility to know your plan details. Estimates and treatment plans are based on information gained from the examination and do not take into consideration any money that was billed toward your financial maximum or treatment limits that may have been used at other dental clinics. Predetermination from your insurance provider(s) are NOT a guarantee of payment.

I have read and understand the Financial Policy Statement. I understand my responsibility for the payment of my account.

_____PATIENT INITIALS

Printed Name:_____

Signed: _____Date: _____