LAM, WELKIE,
& ASSOCIATES
FAMILY AND COSMETIC DENTISTRY

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OFFICE FINANCIAL & APPOINTMENT POLICY

PATIENT NAME: DATE:

THANK YOU FOR CHOOSING US AS YOUR DENTAL HEALTHCARE PROVIDER. WE ARE COMMITTED TO PROVIDING YOU WITH THE HIGHEST QUALITY DENTAL CARE SO THAT YOU MAY ATTAIN AND MAINTAIN EXCELLENT ORAL HEALTH. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE THAT YOU READ, AGREE TO AND SIGN PRIOR TO ANY FUTURE TREATMENT.

PLEASE NOTE: OUR OFFICE ACCEPTS CASH, PERSONAL CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS. ADDITIONAL FEES WILL BE APPLIED FOR RETURNED CHECKS AND ALL BALANCES OVER 90 DAYS ARE SUBJECT TO A $35.00 LATE FEE.

DENTAL BENEFITS ("DENTAL INSURANCE") AND BALANCES

• PLEASE REMEMBER YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. AS A COURTESY TO YOU, OUR OFFICE PROVIDES CERTAIN SERVICES, INCLUDING A PRE-TREATMENT ESTIMATE WHICH WE SEND TO THE INSURANCE COMPANY AT YOUR REQUEST. IT IS PHYSICALLY IMPOSSIBLE FOR US TO HAVE THE KNOWLEDGE AND KEEP TRACK OF EVERY ASPECT OF YOUR INSURANCE. IT IS UP TO YOU TO CONTACT YOUR INSURANCE COMPANY AND INQUIRE AS TO WHAT BENEFITS YOUR EMPLOYER HAS PURCHASED FOR YOU. IF YOU HAVE ANY QUESTIONS CONCERING THE PRE-TREATMENT ESTIMATE AND/OR FEES FOR SERVICE, IT IS YOUR RESPONSIBLITY TO HAVE THESE ANSWERED PRIOR TO TREATMENT TO MINIMIZE ANY CONFUSION ON YOUR BEHALF.

• PLEASE BE AWARE SOME OR PERHAPS ALL THE SERVICES PROVIDED MAY OR MAY NOT BE COVERED BY YOUR INSURANCE POLICY. ANY BALANCE IS YOUR RESPONSILIBITY WHETHER OR NOT YOUR INSURANCE COMPANY PAYS ANY PORTION.

• PAYMENT; UNDERSTAND THAT REGARDLESS OF ANY INSURANCE STATUS, YOU ARE RESPONSIBLITY FOR THE BALANCE DUE ON YOUR ACCOUNT. YOU ARE RESPONSIBILE FOR ANY AND ALL PROFESSIONAL SERVICES RENDERED. THIS INCLUDES BUT IS NOT LIMITED TO: DENTAL FEES, SURGICAL PROCEDURES, TESTS, OFFICE PROCEDURES, MEDICATIONS AND ALSO ANY OTHER SERVICES NOT DIRECTLY PROVIDED BY THE DENTIST.

• FULL PAYMENT IS DUE AT THE TIME OF SERVICE. IF INSURANCE BENEFITS APPLY, ESTIMATED PATIENT CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS ARE MADE.

• UNPAID BALANCE OVER 90 DAYS WILL BE SUBJECTED TO A MONTHLY INTEREST OF 1.0% (APR 12%). IF PAYMENT IS DELINQUENT, THE PATIENT WILL BE RESPONSIBILE FOR PAYMENT OF COLLECTION, ATTORNEY'S FEES, AND COURT COASTS ASSOCIATED WITH THE RECOVERY OF THE MONIES DUE ON THE ACCOUNT.

MISSED APPOINTMENTS AND CANCELLATIONS

YOUR TIME IS IMPORTANT TO US – WE ASK YOU TO TREAT OUR TIME THE SAME WAY. OUR PATIENTS ARE CONSISTENTLY SEEN IN A TIMELY MANNER, AND WE STRIVE TO PROVIDE TREATMENT IN AS FEW VISITS AS NECESSARY. IN ORDER TO PROVIDE THE BEST SERVICES TO OUR PATIENTS, WE REQUIRE 48 HOUR NOTICE FOR CANCELLATIONS OR FOR RE-SCHEDULING YOUR APPOINTMENTS. FOR MONDAY APPOINTMENTS, THIS MEANS THURSDAY BY END OF DAY. A BROKEN APPOINTMENT IS A LOSS TO THREE PEOPLE - THE PATIENT WHO MISSED THE VALUABLE TIME, THE PATIENT WHO COULD HAVE TAKEN THE VALUABLE TIME, AND THE DOCTOR WHO WAS FULLY STAFFED AND PREPARED FOR THE APPOINTMENT.

WE UNDERSTAND THAT UNFORESEEN CIRCUMSTANCES ARISE WHICH MIGHT RESULT IN CANCELING OR MISSING YOUR APPOINTMENT. FOR CLARITY AND CONSISTENCY, WE HAVE DEVELOPED THE FOLLOWING POLICY FOR CANCELLATIONS LESS THAN 48 HOURS PRIOR TO YOUR APPOINTMENT:

MISSED APPOINTMENT	1	2*	3	4
FEE (HYGIENE/DOCTOR)	COURTESY	$35/50	$50/75	DISMISSAL

* IF YOU ARRIVE ON TIME FOR YOUR NEXT 3 APPOINTMENTS THE LATE FEE WILL BE CREDITED BACK TO YOUR ACCOUNT

PLEASE NOTE: PATIENTS WHO ARE 15 MINUTES OR MORE LATE FOR THEIR APPOINTMENT MAY NEED TO BE RESCHEDULED – THIS IS CONSIDERED A MISSED APPOINTMENT. MISSED APPOINTMENT FEES ARE DUE AT YOUR NEXT VISIT AND PRIOR TO ANY ADDITIONAL TREATMENT.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I UNDERSTAND THAT ULTIMATE RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE.

SIGNATURE: DATE: