+Financial Policy Form

FINANCIAL POLICY FORM

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due in full at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Here at Chittenden Dental we take pride in our patient care and in order to provide the highest quality care we schedule appointments with enough time to address our patients needs without feeling the pressure of the clock. However, when patients do not show up to their appointment, that negatively impacts the entire practice and other patients who may be waiting a long time to get their appointment.

Deposits for appointment reservations are NON-REFUNDABLE.

Cancellation/ Missed Appointment Policy:

We appreciate you notifying us ASAP when you are not able to keep your scheduled appointment but we ask that you please give us at least 48 *business-hours* notice before your appointment to allow us to reach other patients waiting to get an appointment.

What is considered a "Missed" Appointment?

- Patient cancels with less that 48 business hours notice.
- Patient does not arrive to the scheduled appointment.
- Patient arrives after the appointment time without enough time remaining and is unable to be seen.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- Due to our payment policies we will keep a secured copy of your card on file for future visits.
- **Payment is due in full at the time of service.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made otherwise. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Responsible party's information

Who is the responsible party for payments? *

- [ ] Patient
- [ ] Someone else

Patients First Name *

Patients Last Name *

Responsible Party Signature *

Today's Date

09/12/2024