**Family Dental Practice**

**Office Procedure and Financial Policy**

Thank you for choosing us as your Dental provider. The goal of the doctors and staff at Family Dental Practice, LLC is to provide the best possible dental care for you and to develop and maintain a relationship with you that will grow and strengthen through the years ahead. Along with our dental relationship, we will be establishing a financial relationship. In order to successfully maintain this relationship, we want you to have a clear understanding of financial policy. Please read, understand and sign this policy statement **prior to any treatment.**

**Initial Appointment**

Once we have received and reviewed your completed paperwork our staff will contact you to set up your new patient appointment. At this appointment you will meet with the doctor assigned to you to come up with a treatment plan. **You will not be receiving a cleaning at this appointment.**

**NOTE**: We do monitor blood pressure at every appointment prior to any procedure for your safety. If it is too high and does not meet the ADA Guidelines deeming you are safe to treat, we will need to reschedule your appointment until it is at a level where we can safely treat you.

**Insurance Verification**

It is your responsibility to verify with your insurance carrier prior to your appointment if our doctors are participating providers with your specific plan. As a patient, you are responsible for understanding your insurance benefits. This includes what items your insurance will or will not cover. This is important as Family Dental Practice cannot be responsible for services provided at non-contracted facilities. As a courtesy to our insurance patients, we will bill primary and secondary dental insurance carriers. Any co-pay for services will be due at the time of service. For us to bill an appointment, you must submit proof of current insurance coverage at the time of the visit. **Without current proof of coverage, payment for the services will be required at the time service is rendered.** If insurance information is submitted after the date of service, we will be glad to bill your insurance and refund your payment.

**Cancellation Policy**

A specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, **please give us at least 48 hour notice** so that we may reschedule your appointment and offer the reserved time for another patient. **We will not reschedule your appointment if we don’t receive the 48 hour notice or if you do not show up for your scheduled appointment.** It is our policy to charge for appointments that have been scheduled in advance and are canceled with less than a 24 hour notice (**this includes same day appointments**). This charge may vary depending on the procedure being performed. We understand things come up unexpectedly and charges may be applied on a case-by-case basis.

**Completion of Forms and Request for Dental Records**

Our office complies with the rules and regulations of The Health Insurance and Accountability Act (HIPPA) and provides safeguards to protect your privacy. Therefore, if you have recent records such as clinical notes or x-rays from a prior dental office, it is your responsibility to have them sent to our office for your scheduled appointment. If we do not receive those records prior to your scheduled appointment, it is our office policy to take new images so the providers can properly diagnose and come up with an appropriate treatment plan for you. If you refuse x-rays at this diagnostic appointment because prior records were not obtained in time, we will cancel the appointment and not reschedule you.

**Maintaining a Respectful Environment**

The doctors and staff thrive to treat our patients with courtesy and respect. It is also important that we ensure that our staff is treated with respect by our patients as well. We feel very strongly that our staff should be able to work in an environment free of abuse. **Angry outbursts against our staff will not be tolerated and may result in your dismissal from the practice.**

**I have read and understand the Office and Financial Policies of Family Dental Practice, LLC**

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**Patient or Parent Signature Date**