OFFICE POLICY REGARDING PAYMENT, APPOINTMENTS AND INSURANCE

OFFICE HOURS ARE FLEXIBLE – EARLY AND EVENING APPOINTMENTS are available on a limited basis, but upon request (i.e. special circumstances). We reserve the right to charge an additional fee for this convenience. Patients are seen by appointment except in emergency situations. If for some reason you have made an appointment which you cannot keep, please notify us at least TWENTY FOUR (24) HOURS prior to the visit during our normal business week of Monday through Friday. PLEASE MAKE SURE TO SPEAK PERSONALLY TO ONE OF OUR PATIENT COORDINATORS REGARDING ANY CHANGE. This courtesy allows us to make time available to other patients. A charge will be made to your account for broken appointments and/or repeated cancellations on the day of the appointment. The charge is a minimum of twenty ($20.00) for each hour that was scheduled for your appointment.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment. We accept cash, checks, MC, Visa, American Express, Discover, and Care Credit. Accounts past due, over thirty (30) days, may be assessed a 1.5% interest charge per month. Should the account be forwarded to collection, you will be responsible for all related collection fees and interest added to your account. We charge a $30 fee for checks returned to our office due to non-sufficient funds.

WE WELCOME SEVERAL DENTAL INSURANCE PLANS. The patient is responsible for the estimated non-covered portion, procedures and/or deductibles at the time of the service. If the insurance company does not pay after 60 days, we will bill you directly for the full balance. In general, benefits should be assigned to us.

INSURANCE POLICIES VARY IN THE AMOUNT THAT WILL BE PAID TOWARD CHARGES. The proper relationship between the patient, doctor and insurance carrier is often misunderstood. We are in agreement with the principle of dental insurance and equally willing to submit the necessary forms to help you receive the full benefits of your coverage; however, the responsibility of the total treatment fee rests with you, regardless of what we may calculate as your dental benefit. We will do everything possible to determine an accurate estimate of your coverage, but because the insurance policy is an agreement between your employer and the insurance company, that insurance company will only give us a NON-BINDING ESTIMATE of what they will pay either in writing or verbally.

I UNDERSTAND that Tioga Dental & Orthodontics will aid in submitting claims to my insurance company on my behalf. I also understand that I have the final responsibility for payment of all fees for services rendered on my behalf. Unless otherwise noted, I authorize payment of dental benefits to Tioga Dental & Orthodontics.

DUE TO THE NATURE OF OUR SERVICES ALL SALES ARE FINAL.

I HAVE READ, UNDERSTAND AND CONSENT TO ALL OF THE ABOVE TERMS.

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Name of Patient or Parent/Guardian (Please Print)

_____

Patient or Parent/Guardian (Signature) Date

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