OFFICE POLICY

Payment will be expected at the time of service for all fees and estimated co-pays.

Insurance contracts: As a courtesy to you, if we have a "Participating Contract" with your insurance carrier, we will accept assignment on all covered services and bill your carrier for you. You are responsible for the co-pay, co-insurance, deductible, and for all non-covered services.

Insurance plans represent a contract between you and your insurance company. These contracts are not between this office and the insurance company. We will do our best to help you obtain benefits, but we cannot be held responsible if your carrier does not pay. Further, if a member of our staff advises you that you are fully covered or implies that you will owe nothing, it is your responsibility to contact your insurance company for verification. Therefore, it is your responsibility to make certain your carrier makes prompt payment, and to handle any disputes that may arise. **If your insurance carrier has not paid your claim within 90 days of treatment, you will be responsible for any unpaid balance. You will also be responsible for following up on the outstanding claim for reimbursement.**

If your insurance is found to not be in effect on the date dental services are provided you will be responsible for the full balance. A finance charge of 18% APR (1.5% a month) will be added to the total balance on all accounts over 60 days past due.

Third party financing may be available for patients requiring extensive treatment through CareCredit. This type of financing must be approved in advance, and is only valid for treatment amounts over $1,000.

If at any time you have questions regarding any treatment, fees, or services, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship.

Missed appointments: Our policy is to charge for missed appointments unless a cancellation is received at least 48 hours in advance. **The charge is $75 per hour of the scheduled time.**

Children in the office: Please make arrangements for your non-scheduled children prior to your visit. Children should not be left unattended in the reception area. All children 17 years of age and under scheduled for treatment **MUST** have a parent or legal guardian present in the office during their appointment.

Cell Phones: We request that all cell phones be turned off or set to silent mode during your appointment.

Family/Friends: For the safety and comfort of our patients and employees, no friends or family members will be permitted to accompany patients in the treatment area during the appointment. Any patients with special needs can make necessary arrangement with the office manager prior to your appointment.

We reserve the right to dismiss any patient from our practice for inappropriate behavior in our office or on the phone.

I acknowledge that I am responsible to pay all charges for treatment administered by Highlands Dental as outlined above and that if my account is placed with a collections agency for non-payment that I will be responsible for all collections costs, including court costs and associated attorney fees.

I have read the policies and agree with the terms outlined above.

Signature: _____

Printed Name: _____ Date: _____