Periodontal Clinic

Practice limited to Periodontics and Implant Surgery

Office Policy Statement

Welcome to our office. We are pleased that you have selected our office for your periodontal treatment. We find that communication with our patients regarding our office policy assists us in providing the best service to the patients and helps avoid misunderstandings. Please, sign at the bottom that you recognize and agree to these terms. Please, feel free to ask us any questions.

Dental Insurance

We are happy to help you file the necessary forms to insure that you receive the full benefits of your policy: HOWEVER, we can make no guarantee of any estimated coverage. Your co-payment is due the date of service rendered. Your insurance policy is an agreement between you and your insurance company. We ask all patients to be responsible for the service rendered in this office. Service provided must be paid for at the time of treatment. There is an interest charged at the rate of 1.5% per month to any account that is 45 days past due.

Appointments

We respect your appointment time and take every effort to begin your treatment as scheduled. We request at least 48 hour cancellation notice if the appointment must be rescheduled. It would allow another patient to use that time. Failure to give us cancellation notice will result in hourly charge of $50.00 for the time that you are scheduled.

Returned Checks and Collection Action

If a check is returned to us for insufficient fund, $25.00 charge will be applied to your account. If you are forwarded to our collection agency, you will be responsible for all charges, including interest fees, late charge fees, collection fees and attorney's fees

Thank you for your time to read this policy statement.

I (We) have read, understand and agree to the above policy.

Responsible party / patient signature_____ Date_____