THE SZIKMAN DENTAL GROUP, P.C.
OFFICE POLICY ON CANCELLATIONS, INSURANCE FILING AND PAYMENT ARRANGEMENTS

We welcome you to our family!

Our office is dedicated to providing the highest quality dental care to anyone who requires it. We use the most up-to-date materials, state-of-the-art technology, and have a caring professional staff to meet your needs. We utilize strict OSHA-approved sterilization methods and materials to ensure your safety as well as that of our staff. The policy listed below should answer any questions you may have about how we handle accounts in our office.

Your appointment time is important to you, to your dentist, and hygienist, and to others who are in need of dental treatment. We charge for missed appointments without an appropriate 24-hour notice. If you cannot keep your appointment for any reason, please call us 24 hours prior to your appointment time. Cancellation notice must be made during regular office hours. If you do not show for your dental hygiene appointment, or if you cancel two times with less than a 24-hour notice, a fee of $35.00 will be assessed. If you do not show for your treatment appointment with the dentist, or if you cancel two times with less than a 24-hour notice, a fee of $75.00 per half-hour will be assessed. You will be personally responsible for this charge. This charge will not be billed to nor paid by your insurance company. Please help us keep the scheduling of appointments fair for everyone.

A ten percent courtesy discount will be extended to senior citizens over the age of 65 who do not have dental insurance. We accept several PPO Access discount plans which allow contracted fees for services performed, however, these plans cannot and will not be used in conjunction with dental insurance.

We file insurance in this office **as a courtesy** to our patients. Additionally, we accept assignment of benefits from your insurance company so that we can receive payments directly. Many dental offices in the area do not even handle insurance. Ultimately, it is the patient's responsibility to deal with his/her insurance company directly should any problems arise. Also, patients are responsible to pay their estimated co-payments directly to our office at the time of treatment.

A patient's co-payment is quoted according to the information we receive from the insurance company. Often, there are hidden clauses in the policy that may reduce benefits. We are not always aware of these at the time we quote the estimated co-payment and therefore, we cannot guarantee what the actual insurance payment will be. Additionally, insurance companies often will change treatment codes to provide for the minimum benefit payable. We do our best to inform the patient of the estimated co-payment, taking all of the above information into account, but again, this is in no way a guarantee. We can only guarantee our actual fee for any given service.

In any event, we expect and appreciate greatly either our estimated co-payment or payment in full **at the time of the visit**. We do not normally extend credit. As of 2006, we no longer perform in-house financing, however, no-interest payment plans through a third party are available for qualified applicants. If for some reason our co-payment estimation is off, we either send a statement for the remaining amount (statements will go out once a month until the account is paid in full), or we issue a credit on the account which can be used toward future work or refunded to the patient directly. The financial coordinator must approve any arrangements for payment other than those stated above.

Patients who keep an open and unpaid account balance over six months will be assessed a mailing fee. Additionally, we charge a $10.00 records duplication fee which is only waived in the case of records being duplicated to send to a specialist referral from one of our dentists.

We greatly look forward to serving you, your family, and friends now and in the future.

By signing this form, I understand all of the above policies of the Szikman Dental Group, and I agree to adhere to and be bound by these policies, understanding that these policies apply to all patients of this practice.

Signature _____ Date_____ / _____ / _____