CEDAR FAMILY DENTISTRY

Dental Office Policies

Please read and initial the following statements.

Scheduling Policy

While Cedar Family Dentistry will make every effort to accommodate our patients' busy schedules, our office policy is to reschedule any patient arriving 15-minutes or later for an appointment, so as not to inconvenience others for whom we have reserved time. In these situations, we may shorten or reschedule the appointment, dependent upon the time we have reserved for others that day.

Patient or Parent/Guardian Initials _____

Pediatric Care (For Parent/Guardian completely form for child)

For all patients who are below the legal age of 18, a legal guardian or parent must be present at the time of the appointment and the scheduling of future appointments. All appointments will be made and confirmed through the parent/ legal guardian.

Patient or Parent/Guardian Initials _____

Cancelation Policy

We require 2 business days' notice (48 hours) to reschedule or cancel dental appointments. After the second missed appointment a charge of $100 will be assessed for late/missed appointment charges. Please respect our practice and other patients' time by informing us as soon as possible when you are unable to make an appointment. You will receive a reminder 2 days prior to your appointment. Monday appointments will be confirmed the Thursday before. Please note that these calls are courtesy calls: your appointment is still your responsibility.

Patient or Parent/Guardian Initials _____

Estimation of Dental Benefits

I understand that Cedar Family Dentistry can only provide an estimation of dental benefits and cannot guarantee payment by my insurance company. I understand that although my insurance states services are covered there is no guarantee of coverage until claims have been processed through the insurance company. I agree to pay any difference of a claim if the insurance does not cover my services rendered. The patient estimated portion determined by my insurance is due at the time of service. It is in my best interest to understand my benefits as coverage varies from plan to plan (even within the same company). It is my responsibility to update Cedar Family Dentistry of any changes to my insurance plan prior to my appointment. If my account should be placed in the hands of an attorney for collections or if suit shall be brought to collect any of the principal, interest or monthly billing fee of the account, I promise to pay reasonable attorney's fee and cost of such suit.

Patient or Parent/Guardian Initials _____

Photography

I understand that as part of my care, photographs may be taken of my teeth and face: the publication or showing of these photographs will be for insurance related and healthcare operations only.

Patient or Parent/Guardian Initials _____

Notice of Privacy Practices (HIPAA)

I have received or was offered a copy of the Notice of Privacy Practices (also known as HIPAA)

Patient or Parent/Guardian Initials _____

Release of Benefits and Information

I authorize my insurance benefits to be paid directly to Cedar Family Dentistry. I am responsible for payment of my account even though an insurance claim has been filed. To the extent permitted under applicable law, I authorize Cedar Family Dentistry to release information relating to the claim. Cedar Family Dentistry bills my insurance as a courtesy; I understand that the contract is between me and my insurance and any non-payment shall be taken up with them.

Patient or Parent/Guardian Initials _____