

## SCHNEIDER DENTAL

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Thank you for choosing our office for your dental care needs. We are dedicated to providing quality service to all of our patients. At your appointment, a thorough examination along with necessary radiographs will be administered. You will receive a thorough explanation of our diagnostic findings and then a personalized consultation to discuss necessary treatment.

The following is a list of our office policies. Please sign at the bottom when you finished reading them. Feel free to ask any questions you might have.

**Cancellation Policy:** It is our policy to require twenty-four hour notice upon cancellation of any appointment. We realize that there may be emergency situations where this is not possible, and those situations will be dealt with individually. A \$30 fee will be charged to your account after three late cancellations or for a failed appointment of one hour in length or less without attempt to contact us. A \$60 fee will be charged for failed appointments over one hour in length. After hours, you may call and leave a message on our answering machine.

**Financial Policy:** Full payment is due at the time of service. We accept cash, checks, Discover, Visa and Mastercard. A \$25 fee will be charged for any returned check.

**Regarding Insurance:** We will happily file your insurance claims for you. We must have all your dental insurance information to file your claim properly. If there are changes in your insurance information, please let us know before your appointment. Our fees reflect what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees and for any treatment administered that is not covered by your plan.** Your estimated portion will be due at each visit, based upon the information we receive from your insurance company. You are financially responsible for any remaining portion not paid by your insurance. A finance charge of 1.5% per month (18% annually) will be added to any balance after 60 days. Should you fail to timely pay all sums due on your account, we reserve the right to bring a collection action against all responsible parties. You further agree to pay all costs incurred in any action, including, but not limited to, court costs and reasonable attorney's fees. We will reimburse you for any payments made to Schneider Dental in excess of services rendered provided there are no outstanding insurance claims.

Again, please feel free to ask any questions you may have. Thank you for placing your confidence in us.

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_