Office Policies

Thank you for choosing our office for your dental needs! We are so glad you are here! We appreciate your trust and look forward to working with you. In order to better serve you, we ask that all patients read and sign our office policies. If you have any questions, please ask the front desk.

1. **INSURANCE:** We are pleased that you have dental insurance! Your dental insurance benefits are a contract between yourself, your employer, and your insurance carrier. We are not part of that contract. As a courtesy to you, we will try to verify your insurance eligibility benefits prior to your appointment. Please notify us immediately if your insurance coverage changes. Not all dental services are covered under your dental policy. Each policy varies in exceptions, exclusions, waiting periods, and limitations. Your insurance is your responsibility; you are ultimately responsible for knowing all guidelines, exclusions, waiting periods, and limitations. Should you have any questions or need explanations about your insurance benefits, please ask. **Insurance estimates are provided as a courtesy and are never a guarantee of your benefits.** If your insurance carrier pays less than the estimated amount, you are responsible for the remaining unpaid balance. **You are responsible for the balance if insurance benefits are denied**.

2. **FILING INSURANCE:** As a courtesy to you, we will electronically file insurance claims and accept assignment of benefits on your behalf. Often, the insurance company will request additional information such as a college student's full-time status, proof of enrollment, etc. Failure to provide additional information to our office may result in a denial of insurance benefits.

3. **PAYMENT:** Payment is due at the time of services rendered (this includes yearly deductibles, copayments, and/or estimated out of pocket portions). Additionally, if you have an outstanding balance following an insurance payment, you will be expected to pay the balance prior to additional treatment. We accept Visa, Mastercard, cash or check.

4. **OVERDUE BALANCES:** If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days of notification, your account will accrue a 5% interest charge for each month the balance is outstanding. We reserve the right to cancel any future appointments that you may have with us if the balance is not paid within 30 days. If your account exceeds 90 days past due, your account will be turned over to a collection agency. In this event, there is a collection fee (39% of the balance) that will be added to the balance.

5. **RETURNED CHECKS:** There will be a $30 fee for all returned checks. In the event of a returned check, your balance and fee must be paid via credit card or money order within 10 days of notification. If it is not paid, we will treat it as an overdue balance.

6. **CHANGES IN PERSONAL INFORMATION:** Please notify our office of any changes in your address, telephone numbers, or email address.

7. **CANCELLATIONS/FAILED APPOINTMENTS:** We reserve the right to charge a fee of $50.00 for any hygiene appointment and $100 for any doctor visit missed or cancelled **without a 48-business hour notice**. If a conflict with your appointment time arises, please call us immediately.

8. **INTERNET COMMUNICATIONS:** We are a paperless office! By signing the office policies form below, I also grant my permission to the dental office to upload and store confidential information to the secured website of the dental practice. I also grant my permission to the dental practice to file my insurance claims electronically.

***I have read and understand the office policies of the practice and agree to the terms.**

Patient Name: _____Signature: _____ Date: _____
(Or guardian if applicable)

Notice of Privacy Practices Patient Acknowledgement

As of December 1, 2013, Benton Family Dental has updated the Notice of Privacy Practices. I have read and understand the practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. I can ask for a copy of the privacy practices at any time.

Patient Name: _____Signature: _____ Date: _____
(Or guardian if applicable)