

# Office Policy

Name: \_\_\_\_\_

Please initial to acknowledge our policies at each line

## 1. Payment

### Payment Arrangements For All Patients

\_\_\_\_\_  
Initials

Payment is expected at the time service is provided. Cash, personal checks and most credit cards are accepted. Delinquent accounts over 90 days may be referred to a collections agency. All fees incurred from the collection agency will be charged to the account. If legal action is necessary than all fees are the responsibility of the patient.

## 2. Insurance

### Payment Arrangements For Patients with Dental Insurance

\_\_\_\_\_  
Initials

Periodontal Specialists only contracts with Delta Dental Insurance. As a complementary service we will file your claim with your insurance company. This service requires you provide us with all current and accurate information required by your carrier. Payment in full for services will be required at time of service, and any payment for your insurance company will be provided directly to you.

## 3. Cancellations

### Cancellation Policy

\_\_\_\_\_  
Initials

If the need to cancel a scheduled appointment arises, we request 24 hours notification. Short notice cancellations or missed appointments are considered "failed" and will be handled on a case by case basis which may result in a failed appointment fee. If multiple failed occur this could result in a dismissal from our office.

## 4. Reminders

### Reminders

\_\_\_\_\_  
Initials

For your convenience, we provide appointment reminders via text messages, email or phone call. This is a courtesy to you and ultimately keeping your scheduled appointment is your responsibility.

## 5. Warranty

### Quality Guarantee

\_\_\_\_\_  
Initials

We stand behind the materials and techniques used in our office and provide replacement of any failed dental materials at no cost to the patient for a 12-month period beginning at the time of service. Exceptions to this guarantee will include failure due to trauma, recurrent decay, parafunctional habits and/or failure of the patient to comply with recommended treatment plans and/or recommended recare (cleaning) schedules.

## 6. Privacy

### Patient Privacy

\_\_\_\_\_  
Initials

Our practice is committed to securing the privacy of your health information. Accordingly we have provided you with a copy of our practice's **Notice of Privacy Practices**. We would like your acknowledgement that you received this **Notice of Privacy Practices**. We also ask that you consent to our sharing of your records to coordinate with Dental and/or Medical professionals and Insurance Companies by signing below.

Date \_\_\_\_\_ Signature \_\_\_\_\_