TOTAL HEALTH
DENTAL CENTER

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OFFICE POLICY

Dear Patient:

We would like to take this time to welcome you to our dental office and thank you for selecting our practice at which you will receive your dental care. Our office's utmost goal is to provide quality care to meet the dental needs of your family, from general dentistry to other services including periodontics, oral surgery, endodontics, implants and cosmetic dentistry.

To facilitate efficient handling of your financial account, we request that all **copay fees be paid in full at the time that services are rendered** unless prior arrangements are made with our office staff. We are more than glad to aid in submitting your third party insurance coverage and we gladly accept assignment of benefits from most carriers including many PPO plans, however it is the final responsibility of the patient to satisfy any balances left unpaid by the insurance carrier. The insurance policy that you bring into our office is a contract between die patient, or employer, and the insurance carrier. Our dental office has no control over the quality of insurance coverage you or your employer has contracted with. It is our goal to render the highest quality dental care available and we have NO control over the many unjust "cost containment policies" insurance carriers use to reduce your benefits.

In an effort to make quality dental care more affordable and to facilitate efficient processing of your account, we have many options available to you including credit card, check and cash usage. We also offer preauthorization credit card usage, however, we are not able to offer credit directly from the dental office. Our office provides a 60 day grace period to satisfy any unpaid balance including pending insurance benefits, whereupon we assess a 18% yearly carrying fee to past due balances with a minimum carrying fee of $2.00/month. These additional service fees are used to discourage the patient from floating unpaid balances.

In the event that a check is returned by the bank, or a credit card transaction is voided, a $35.00 service fee will be assessed to cover our additional expenses. This office reserves the right to use any legal means possible to collect on unpaid balances including outside collection institutions, municipalauthorities, and credit card balance billing. Cost of collections to be patient currently at 40% of the outstanding balance that was sent to the collection agency.

We try to remind patients by telephone prior to the appointment, but please do not depend on this courtesy. If we are unable to contact you, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present.That time has been reserved especially for you. If you need to change your appointment, we require at least 48 hours notice for all cancellations to avoid a charge for our lost time and to avail the time to other patients. On the other hand, dental emergencies do arise and if we are unable to see you at the appointed time, please have patience, as one day you may be in need of emergency treatment.

Thank you again for choosing our dental office. We look forward to providing for your dental needs. If you have any questions, please feel free to consult with one of our staff members.

Affixing a signature below implies an understanding of our office policies and the willingness to abide by these policies in order to render quality dental care in an efficient manner.

PATIENT OR GUARDIAN SIGNATURE_____ DATE_____