PENINSULA FAMILY DENTISTRY
A DIVISION OF ATLANTIC DENTAL CARE

MISSED APPOINTMENTS

Once your appointment has been made, please remember that this time has been reserved especially for you with one of our dental professionals. We do not customarily charge a patient for the first broken appointment, but we reserve the right to charge $35.00 for the second and any additional broken appointments without **48 hours prior notice.**

INSURANCE ASSGINMENTS

If this office is able to accept your insurance company's assignment, it does not absolve the patient of full responsibility for charges in full for the treatment rendered. Any estimate provided by this office is considered as a guideline until the final insurance payment is received and the patient's account has been reconciled. **This office can make no guarantee of the insurance payment as estimated**. The agreed upon payment for the patient's estimated portion must be kept current or the assignment will be canceled and the full amount due will become due and payable. Claims are submitted promptly after treatment is rendered and if not paid by the patient's insurance company by the 45th day after treatment, payment will be due in full from the patient. Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer your questions.

COLLECTION FEES

If your account is assigned to an outside collection agency or attorney for collections, you will be responsible for the balance plus any and all fees that may apply, including court costs. Submission to treatment is given consent.

FINANCIAL CONSENT

The patient/guardian agrees to be fully responsible for the total payment for procedures performed in this office, including any treatment not covered by their dental insurance. **Your estimated copayment not covered by your insurance is due on the date of service.** I understand that if financing is required, credit bureau reports may be obtained. I certify that I have read, understand and agree to pay Peninsula Family Dentistry for all services rendered, and that the information given is correct, to the best of my knowledge.

Patient's Signature ________________________________ _ Date______________________

Parent or Guardian Signature (if Minor) ___________________________ Date ________________