Kent Island Dentistry, LLC

OFFICE POLICY, PROCEDURES AND INFORMATION

PAYMENT

Payment is due at the time the service is rendered. If you use your insurance benefits, your cost-share is determined by your **insurance plan** and can include a deductible. Payment of the cost-share and deductible is considered your responsibility and not that of the insurance company. We do not offer payment plans, however we do accept **CareCredit** (Ask for details).

INSURANCE

We are contracted with most PPO plans and will use the "schedule of maximum allowable charges" as our fee basis for covered services. We always attempt to provide you with an accurate estimate; however, information regarding covered procedures rendered at another office may not be available, and they may affect your future coverage. Any portion that your insurance denies will be your responsibility to cover. **Therefore, it is your responsibility as the patient to fully understand your dental insurance policy, including maximums, deductibles, and limitations.**

By initialing here, I acknowledge that I am aware of the payment and insurance policy. _____

CANCELLATIONS AND MISSED APPOINTMENTS

We will confirm via telephone, email, or text message. **We ask for at least 24 hours notice if you need to change your appointment time**. We reserve the right to charge a **$50.00 per scheduled hour fee** for patients who are not present for their scheduled appointments and for patients who fail to give us sufficient notice that they have a conflict. Patients with a history of failing appointments or repeated late cancellations may be dismissed from the practice. In our office, time management is key. Please be respectful of others by arriving at your appointment on time. As a courtesy to other patients, if you are more than 10 minutes late, we reserve the right to cancel the appointment.

By initialing here, I acknowledge that I am aware of the appointment policy. ____

OTHER FEES/CHARGES

Returned checks will be subject to a $35.00 fee. When an outstanding balance has to be forwarded to our collection agency, you will be responsible for any collection costs incurred.

Your signature indicates that you understand and agree to comply with these policies and procedures.

_____ _____

Printed name of patient **Date**

_____ _____

Signed name of Patient or Responsible party **Relationship to patient**