OFFICE POLICIES
Delwyn L. Dick, D.D.S.

Our philosophy is to provide the highest quality of patient education and dental care to all of our patients. To ensure that you begin with a positive experience we have prepared the following information for you to review. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT

In order to keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience we will provide you an estimate for services in advance of your appointment/s to ensure you opportunity to plan in advance for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

_________ Initials

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We ask that you familiarize yourself with your insurance benefits, and provide us the correct information for the submittal of your claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 60 days. Please remember that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee any estimated coverage. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

_________ Initials

PAYMENT OPTIONS

For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service.

Cash or Check ______ Visa / MasterCard______ Extended Payment Options ______ (Please see below)

Should you desire a monthly payment plan we invite you to complete a simple finance company application. There are no application fees or a down payment and the loan can be interest-free. Approval is provided to you quickly.

PAST DUE BALANCES

Any balance owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 60-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. All balances over 60-days are subject to a $10.00 rebilling fee.

_________ Initials

CANCELLATION NOTICE

If you are unable to keep an appointment that has been reserved for you, we request that you provide us with a 24–48 hour courtesy notice. The earlier you notify us ensures that we can offer you a more convenient appointment and it allows us more time to invite another patient in for the care they need filling the open time you are unable to keep. We realize that emergencies do occur and we will be flexible under those circumstances; however, other missed appointments without the requested notice may incur a $50 fee. Please be advised that three (3) missed appointments without the requested notice within a 12-month period of time may result in dismissal from our practice.

_________ Initials

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to your medical history, telephone number/s, address, employer or insurance information as they occur.

_________ Initials

My signature indicates that I understand that policies as outlined and any questions I have with regard to office policies have been answered.

_________________________________ _______________

Signature of Responsible Party or Patient Date

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

_________________________________ _______________

Signature of Staff Member or Doctor Date

Customized for Delwyn L. Dick, D.D.S. by Dental Management Solutions, Inc. 2003