DENTAL CARE CENTER OF HOLLYWOOD

OFFICE POLICY

Dear Patient:

Thank you for choosing us as your family dentist. The following is our Office Policy. Our main concern is that you receive the proper and optimal treatment needed to restore your dental health. Therefore, if you have any questions or concerns about treatment options or payment policies, please do not hesitate to ask a member of our staff.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the Dentist.

Payment is due at the time the Treatment Plan is accepted. We accept Cash, Debit Cards, Master Card, Visa, American Express, and we also offer 3rd Party Financing. WE RESERVE THE RIGHT TO ACCEPT CHECKS.

At our discretion, we may accept assignment of Insurance benefits – however you must understand that:

All charges are your responsibility whether your insurance pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Any co-payments we collect from you are only estimates based on what we are expected to receive from your insurance company.

Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. These fees are collected BEFORE you are seen to avoid a back up at the front desk.

Balances older than 30 days will be subject to finance charges. In the event it becomes necessary for your account to be handled by an outside collection agency, you will be responsible for any costs and/or attorney's fees.

Please note that, unless appointments are cancelled at least 24 hours in advanced, you may be charged for the missed appointment. Please be advised should you miss another appointment or fail to cancel within the time specified, you may be dismissed from our office and your insurance carrier will be notified of your non-compliance.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so we can assist you in the management of your account.

Patient Signature: _____ Date: _____