

FAMILY DENTISTRY OF COLUMBUS, P.C
OFFICE POLICIES

Financial Policy:

Payment is expected at the time of service unless prior arrangements have been made. We accept cash, checks, Visa, Mastercard, Discover, American Express & Care Credit. If you have questions about the fees for services you are to receive, just ask and we will be glad to help you.

Insurance Policy:

For our patients who have insurance to help with the cost of their dentistry, we offer the convenience of filing your claims for you. Please present us with your current dental insurance card at the beginning of your appointment or if you are made aware of new coverage between visits please call our office to let us know so we will be prepared for your next appointment. We are a participating, in-network provider with many dental insurance plans. We are glad to offer this service to you and help you in any way possible. In this regard we would like to offer the following tips:

1. Know your plan. If you have questions regarding what your insurance will cover, call the number on your card and ask that your benefits be explained to you. **The more you know the less likely it is that you will receive any unexpected bills.**
2. Call your insurance company or ask at the front desk, prior to your appointment, what your estimated co-payment will be. This amount is reached based on the information your insurance company gives us. **It is only an estimate.** You are responsible for any amount not covered by your plan. Insurance policies vary greatly and we can only estimate your coverage.

Appointment Policy:

As a courtesy, our office will attempt to contact you for confirmation 1-2 days before your appointment. However, we do ask that our patients/parents assume responsibility for your appointment time. Broken appointments or short term cancellations (within 24 hours) without proper notification can be costly to our office and unfair to other patients who need appointments. There is a minimum \$35 charge for broken appointments or appointments cancelled without 24 hour notice. This amount is determined by the amount of time required on the schedule. We do know that unforeseen situations arise and we are willing to work with you. We ask that you respect our time and also the time of other patients who may be on a waiting list to schedule an appointment.

I have read and agree to comply with the above policies:

Patient name: _____

Patient / Parent (if minor) Signature: _____ Date: _____