

Patient Responsibilities

The particular plan which you have is a contract between **yourself and the company providing the benefits**. We will try to advise you as to what services are covered under your plan and approximately how much you can expect to receive from the insuring company. Please bring in your contract or brochure so that we may discuss it with you.

As the patient, you authorize the treatment and are solely responsible for the payment of the fees. We will, however, gladly submit any insurance claims for the treatment done as well as any pre-determinations that you require to your insurance company on your behalf.

You may pay your account yourself, and be reimbursed by your plan, or we will accept assignment of your dental plan on the following basis only:

- a. At the time of treatment, you pay the percentage which the plan does not pay. (i.e. if you are covered 80%, you will be responsible for the 20% as services are rendered.)
- b. If the payment is not received from your plan within the customary thirty days, we will notify you for payment. We will then re-submit the claim directing payment to you. (For dual insurance we will allow up to sixty days.)
- c. If there is a balance owing on your account after receipt of the insurance cheque(s), we will send you a statement indicating the balance.

Your appointments are reserved especially for you. We understand that your time is important to you and we hope you appreciate that it is also important to us.

**Patients are responsible for knowing the time and date of their appointment.**

- **If you are unable to keep a scheduled appointment, 48 hours' notice must be provided. Failure to do so may result in a minimum \$50.00 charge for a missed appointment and/or late cancellation. **\*\*If your appointment is on a Monday or Tuesday AFTER a holiday Monday, you must call to cancel by the Friday morning before that weekend\*\*****
- **Changes to work schedules, meetings, forgetting appointments, lack of transportation, missing rides/busses, or not receiving a reminder; reasons such as these may be subject to missed appointment/late cancellation fee.**
- **More than one missed appointment may cause us to consider dismissal and requesting you to seek the services of another dental office.**

Thank you for your commitment and understanding.

I have read and agree to comply with the above conditions.

Date \_\_\_\_\_ Signed \_\_\_\_\_