

# ARTISTIC DENTAL OFFICE POLICY

*We are here to serve you in a comfortable and professional atmosphere. We are committed to providing you with the very best quality of dental care. Our goal is to make your experience an exceptional one. If your visit with us did not meet your expectations, please tell us. Your opinion matters and helps us determine the areas where we are doing well and where we can improve.*

## Scheduling and Office Policy

**(PLEASE READ CAREFULLY AND CHECK ALL BOXES):**

We strive to see all of our patients on time. We ask that you please arrive at least **15 minutes** in advance of your scheduled appointment time. If you do not arrive 15 minutes ahead of your appointment time, we cannot guarantee that all services will be able to be completed as planned, as the staff will be limited in the amount of time allocated to treat you.

I acknowledge and agree to the above statement.

Your appointment time is a reservation between you and the Dentist or Hygienist, and is set aside especially for you; therefore we ask that you make every effort not to change a scheduled appointment. If you must reschedule an appointment, we kindly require notice a minimum of two business days in advance. Although we understand that emergencies do occasionally arise, there may be minimum fee of \$50 incurred for all broken appointments (No-Shows) or appointments cancelled without two business days notice, Failure to keep a scheduled appointment not only compromises your dental health, but prevents other patients from receiving necessary care.

I acknowledge and agree to the above statement.

If you No-Show to an appointment without an advance phone call, all other scheduled appointments will be cancelled. We will be able to reschedule those appointments on a day that works better for you, however there will be a fee due to satisfy the No-Show and/or a non-refundable deposit may be required, in advance, in order to reschedule any future appointments. Repeated No-Show appointments without an advance phone call, will result in dismissal from the practice or same day appointments only.

I acknowledge and agree to the above statement.

Treatment Planning Policy: Our office prides itself on making the very best treatment recommendations for our patients; therefore we do not let insurance limitations and allowances dictate our treatment recommendations. We are committed to taking the very best care of you, your oral health and your overall well-being. It is important to remember that you are a partner with us in your oral health and that treatment decisions should be made together, based on your needs.

I acknowledge and agree to the above statement.

## Financial, Billing and Dental Insurance Policy

Patient Payment Policy: For your convenience, we accept checks, cash, Visa, Master Card, Amex, Discover and Carecredit. When receiving a statement for a balance owed, all payments are due 10 days from the date of the statement. Please note, we also utilizes text messages and emails for any balances owed. Balances over 180 days old are subject to being sent to Collections. The patient assumes the costs for any collection attempts.

I acknowledge and agree to the above statement.

We are an insurance friendly office and accept most major PPO plans. We do not participate with any DMO or DHMO plans. If you have a DMO or DHMO plan, you are welcome to come here, but you will not be able to use your benefits. If we are “out-of-network” with your plan, we will be happy to assist you with using your benefits. When scheduling, please have your dental insurance information ready. If your dental insurance should change, please let us know in advance of your appointment, when possible.

I acknowledge and agree to the above statement.

We have designated team members that are happy to assist you with understanding your insurance benefits; however, it is your responsibility to be fully aware of the details of your benefits, specific plan parameters, network participation and if you have used a portion of your benefits at another office. We bill your insurance our full office fees, and you are responsible for the regular office fees, unless your insurance company dictates otherwise. Your dental benefits may not cover the full cost of the specific treatment that you require; however, we will do everything we can to help you maximize your benefits.

I acknowledge and agree to the above statement.

As a courtesy to you, we will estimate your portion of your financial investment. The estimated patient responsibility is due prior to or at the time of your visit. Please be advised that this is an estimate only, and although we gladly file insurance claims for you, any and all balances and uncovered procedures are ultimately your responsibility. The estimated insurance benefits that our software may generate is not a guarantee of benefits, as our system calculates based on generalized and typical insurance benefits which may differ from your specific plan benefits, parameters and limitations. Our office software is not directly linked to your insurance company and your insurance company will never guarantee benefits for anyone. Any balances that have not been satisfied by insurance that are over 60 days old, are ultimately your responsibility.  I acknowledge and agree to the above statement.

All insurance benefits are assigned to the Doctor and dental records may be released to the insurance company.

I acknowledge and agree to the above statement.

Cancelled Checks and Overdue Balances Policy There will be a \$35 cancelled check fee applied to your account in the event that your check payment should not clear for any reason. Accounts are turned over to collections when an overdue balance reaches 180 days overdue. At that time, payment arrangements will not be offered and payment in full is expected in order to remove an account from collections. Any collection fees will be your responsibility.

I acknowledge and agree to the above statement.

## Responsible Party Policy

For children under the age of 18, the Parent that brings the child to the appointment is the person responsible for all charges, regardless of who the insured parent is.

\_\_\_ I acknowledge and agree to the above statement.

For dependents from the age of 18 to 23, IF the child was registered with the practice during the age where a parent would have been responsible for the charges, THEN that parent will continue to be responsible until they notify the practice that they are no longer responsible AND the dependent signs their own office policy acknowledging that they are now responsible for their own charges going forward. Any charges incurred during this transition will always be the responsibility of the initial responsible party.

\_\_\_ I acknowledge and agree to the above statement.

For Spouses, regardless of insurance connection, each spouse will always be responsible for their own charges. Please note that accounts are usually linked within a family and only one family member can be listed as Head-of-Household (name on statements) and it is that person's responsibility to notify their spouse of their individual financial responsibility and any balances due. Accounts can be split upon request only, otherwise they will be joined.

\_\_\_ I acknowledge and agree to the above statement.

## Communication Policy

**For communication with patients:** When contacting patients directly, we will leave detailed information via email, voicemail or text message, unless otherwise requested by the patient, in writing.

**For third party communication:** Under the requirements for H.I.P.A.A. we are not allowed to give your information to anyone without your consent. If you wish to have your dental treatment and/or financial information released or discussed to any family members or acquaintances of any kind you must complete a separate Authorization to Release Information form that you can request from our Admin Team at any time. You must list the name, relationship and means of communication allowed for every person that you wish for us to share your information with. This may include your spouse, significant other, parents, grandparents or children.

You have the right to revoke this consent in writing.

\_\_\_ I acknowledge and agree to the above statement.

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PRINT NAME OF PATIENT

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

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DATE