Claremont Design Dentistry
Office Policies

Appointment and Cancellation Policy

We make every effort to schedule your appointment at your most convenient time. It is very important that you keep your appointment as scheduled. This dental practice is committed to improving your oral health. You on the other hand, must be committed in making your scheduled appointment time. This will then enable you to receive all necessary dental treatment for the best of your oral hygiene.

Our policy concerning cancelled or failed appointments is as follows:

- A patient with an appointment must call at least 24 hours in advance prior to canceling or rescheduling their appointment time. Same day cancellations and/or rescheduling is not permitted and will result in a $45.00 (forty-five dollar) failed or cancellation charge, which will be billed directly to you.
- This above failed or cancellation charge applies for EACH occurrence. After the third cancellation or failed appointment, we will treat you for thirty days on an emergency basis only. At this time, we will give you an opportunity to find another dental office.

Assignment or Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions, it is important to understand, though, that the contract regarding your dental benefits is between you, your employer and your insurance company. The obligation you have with our practice is to pay for services rendered, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payments directly to our office.
- We require you to pay the co-payments, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within thirty to sixty days from the time of billing. If your insurance company has not made payment to our office within sixty days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company request to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and request of your insurance company. It is ultimately your responsibility to resolve any type of dispute referring to any insurance claims pending payments not made by your insurance company.

I have read and understand the above conditions. I hereby authorize my insurance company to pay my dental benefits directly to the doctor.

_____ _____ _____

Signature Date

_____ _____ _____

Witness Date