HOPEWELL FAMILY DENTISTRY FINANCIAL AND APPOINTMENT POLICIES

We at Hopewell Family Dentistry have a primary mission to deliver quality and comprehensive dental. We feel that your clear understanding of our financial policy is important to our professional relationship.

INSURANCE
If you have insurance, we will help you receive maximum benefits and as a courtesy process your insurance claim. However, it is important to remember that the insurance is a contract between you and the insurance company. We currently accept all private care insurance plans. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. The total not covered by insurance is DUE AT THE TIME OF YOUR APPOINTMENT. If your insurance company has not paid the FULL BALANCE within 45 days, you will be responsible for any remaining balance. If your insurance company pays more than the balance due, we will send a refund check to you.

If you would like to know your exact out of pocket expense you may require, a "pre-treatment authorization" can be filed but a delay in treatment time is to be expected. Please Initial ________

PAYMENT OPTIONS
1. Cash
2. Personal Check
3. Visa, MasterCard, Discover
4. CARECREDIT: offers patients a line of credit to cover you or your family's dental care needs. We accept the 6 and 12 month carecredit pay options.

Any fee estimates for dental services will only be extended for a period of six months from the date of estimate.

APPOINTMENTS AND CANCELLATIONS

When we make your appointment, we are reserving a room for your particular needs. We ask that if must change an appointment, please give us at least 24 hours notice from your appointment time. This courtesy makes it possible to give your reserved room to another patient who would like it. We reserve the right to charge a fee for broken appointments or ones that are not cancelled beforehand in a reasonable time frame. Repeated late cancellations or missed appointments will result in loss of future appointment privileges or dismal from the practice. Please Initial _________

ADMINISTRATIVE FEE (If applicable)
* Returned checks are subject to a $35.00 fee
* If collection and/or legal services are require to obtain payment, I further agree to pay for all legal and costs incurred.

I understand and agree that, regardless of my insurance (if applicable), I am ultimately responsible for the balance on my account for all charges and services rendered. I have read all the information on this sheet.

If you have any questions, please feel free to inquire before signing below.

I have read and understand the above policies.

Patient Signature:____ Date: ____________