Please read, initial, and sign that you understand each of our company's financial and appointment policies.

_____ ***Co-Payments:*** All Applicable deductibles, co-insurance amounts, and non-covered services amounts are due at the time service is rendered. All payments are collected before you are seen by the doctor and any adjustments that need to be made can be made at the end of your visit.

_____ ***Deposits:*** Patients must pay a deposit in order to reserve appointments for major restorative work. Most procedures that fall within this category are root canals, crowns, bridges, partials, implants, and/or restorative appointments that will require 1 ½ hours of time or more. The deposit is equal to half the patient's co-insurance amount for that procedure of 50% of the procedure cost.

_____ ***Forms of Accepted Payment:*** Cash, personal checks, Master Card, Visa, American Express, Discover, Care Credit, and Lending Club are all acceptable forms of payment in our office. Picture ID is required in conjunction with all forms of payment except cash.

_____ ***Returned Checks:*** There will be an applicable fee for returned checks in our office; the fee will be $40 for any check with a face value not exceeding $300; should the face value exceed $800 the fee will be 5% of the check. Your bank may also charge you additional fees not associated with our office.

_____ ***Payment Plans:*** We do not offer in-house financing; however, we have partnered with Care Credit and Lending Club which offer several short term no-interest and long term payment plans with minimal interest. You can apply for Care Credit in our office with the assistance of a staff member, over the phone at 1-800-365-8295, or online at www.carecredit.com. You may apply for Lending Club in our office with the assistance of a staff member, over the phone at 1-800-630-1663, or online at www.lendingclub.com/dental.

_____ ***Contracted Insurance:*** As a courtesy, we file any contracted dental insurance claim so long as you provide us with the correct insurance information, a copy of the insurance card, the insured's social security number, and picture ID. You will be required to pay for your visit in full at the time of service if you are unable to provide all above named items. The benefits you receive are based on the contract between you or your employer and the dental insurance company not our office. Some services you may need or want may not be covered by your benefit plan. Our goal is to help you achieve and maintain optimal dental care and we will not compromise your care based on restraints of an insurance company.

_____ ***Non-contracted Insurance:*** Payment is due in full at the time of service for patients who have a non-contracted insurance policy. We do not file dental insurance claims with non-contracted dental insurance companies. We are happy to provide you with all the necessary claim forms and information to file your claim for reimbursement.

_____ ***Cancellation Fees:*** We reserve the right to charge up to $100.00 for any missed, no show, or appointment cancellation without 48 hours notice.

_____ ***Unpaid Insurance Balances:*** Every effort is made to process your dental claim efficiently and quickly as well as to calculate your patient co-insurance amounts for each date of service. However they are still only estimates based on the current information you and your dental benefit plan provided to our office. The exact amounts are not known until the claim has been paid. You are responsible and will be required to pay for any balance amount remaining on your account after 60 days. Any accounts that are sent to collections will be charged a $50.00 fee.

_____ ***Account Balances:*** We provide monthly statements to alert you to any remaining balances on your account. Please remit payment of any balance upon receipt. You can choose to mail your payment, stop by the office, or pay over the phone with your debit or credit card. If you choose to pay by phone, you will be required to fill out a credit card authorization form and fax or email us a copy of your picture ID.

_____ ***Account Balances Over 90 Days Old:*** Every effort is made to inform you of your account balance. Our office mails statements and makes courtesy phone calls in an attempt to collect any owed balances. We instill the help of an outsourced collection agency once we have exhausted our efforts to contact you and collect your balance that remains after 90 days. Any accounts that are sent to collections will be charged a $50.00 fee.

_____ ***Extension of Treatment:*** We will extend emergency care **only** to patients with past due accounts. You will be required to pay for your emergency care visit in full at the time of service. We will not allow new treatment to be scheduled for patients with past due accounts.

_____ ***Children Under the Age of 18:*** Children under the age of 18 MUST have a parent/guardian present for the entirety of their first dental visit in our office. You may elect to sign a consent form for another responsible adult to accompany them on each subsequent visit or to attend on their own if of driving age. A new consent form is needed for each date of service. No exceptions can be made.

_____ ***Scheduling Appointments:*** Patients are seen by appointment only. Your time is reserved just for you; we do not double book appointments. Same day or next day appointments will be given based upon availability and or emergency situation. Emergency services will be accommodated to the very best of our ability on the same day of your call. As every effort is made to be on time for our patients, we ask that you extend the same courtesy to us by arriving on time for each of your visits as well.

_____ ***Courtesy Reminder Calls:*** As a courtesy we provide a **48 hours (2 business days)** reminder call for all reserved appointments. We must speak with the patient or responsible party member directly in order for the appointment to be considered confirmed. We will make every attempt to reach you by all telephone numbers and e-mail provided. It is the patient's responsibility to return our confirmation phone calls and e-mails. You will forfeit your reserved appointment time if we cannot confirm your appointment within **24 hours (1 business day)** of your scheduled time.

_____ ***Canceling Appointments:*** We trust that no change in your appointment will be necessary. However if this becomes necessary we require 48 hours (2 business days) notice to make changes in your reserved appointment time. We recognize that emergencies do occur but abuse of our time could result in being dismissed from our practice. Please help us serve you better by keeping all reserved appointment times.

_____ ***3 & 6 Month Recall Appointments:*** We make every effort to schedule 3 or 6 month recall cleaning appointments 6 months in advance. When you are seen for your new patient exam and cleaning, please be prepared to schedule your 6 month recall appointment.

We will be glad to discuss any questions you may have about our financial or appointment policies. We hope by presenting our policies, we will avoid any misunderstanding and therefore have more time to dedicate to your dental care. I hereby authorize all claims to be filed on my or my dependents behalf, for the use of "my signature on file" for all insurance claims and for benefits to be assigned to Ligon Dental Group and any of its associated companies, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my healthcare information for the purpose of obtaining payment for services and determining benefits. This consent will remain in effect for as long as I or my dependents are a patient of record.

Patient Name (Print): _____

Print Parent/Guardian Name: _____

Patient/Guardian Signature: _____ ***Date:*** _____