CRANSTON COSMETIC DENTISTRY

Office & Financial Policy

PATIENT INFORMATION					
First Name		Last Name		Birth Date	

INSURANCE

As a courtesy to you we will help process all your insurance claims. Please understand that we will provide an insurance ESTIMATE to you, however it is not a guarantee that your insurance will pay exactly as estimated. We must emphasize that as your dental care provider, our relationship is with you, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Patients are encouraged to check with their insurance plans on what dental services are covered prior to visit.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

PAYMENT

You are required to pay your estimated portion for all services by cash, check, or credit card at the time we provide the services to you. Outside financing is available through Care Credit upon request and approval.

Returned checks will be subject to additional fees. Patients with balances older than 30 days are subject to a ten-dollar ($10) statement fee with 1.5% monthly interest (18% annually) plus all costs of collection services, including attorney's fees.

APPOINTMENTS

In providing the highest quality of care to each of our patients, accurate scheduling is important. For that reason, we have created a cancellation policy to ensure that we can serve all of our patients in a timely manner. Our cancellation policy is as follows: 1. You must provide at least 24 hours' notice before the scheduled date and time of the appointment you are canceling. 2. Appointments cancelled with less than 24 hours' notice will be charged fifty dollars ($50). We understand unusual circumstances may occur and with an explanation the fee may be waived. I acknowledge that I have read and understand this policy, and agree to pay a fifty-dollar ($50) cancellation fee if I provide less than 24 hours' notice when canceling an appointment.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerned your care or our financial policy.

FORM COMPLETION			
I have read and understand and agree to the above terms and conditions			
Signature of Patient, Parent or Guardian:		**Date:**	
IF PATIENT IS A MINOR			
Form signed by:		**Relationship to Patient:**	