

# Matthews Family Dentistry

## OFFICE POLICY

Payment in full is expected at the time of services are rendered unless other arrangements are made in advance. For your convenience, we accept the following credit cards:

**Visa, Mastercard, Discover and American Express**

***Personal checks not accepted***

An insurance policy is a contract between the insured and the insurance company. We will assist you with filing your primary insurance as a courtesy to you. You will need to pay your deductible and co-payment at the time services are rendered. You must be responsible for filing your secondary insurance if you have any.

Any outstanding account not covered by your insurance company will be your responsibility.

A finance charge will be added to all accounts 30 days past due. Any outstanding account balance 90 days or older with no activity will be turned over to a collection agency or Magistrate court. It will be your responsibility to pay for any and all collections fees or court charges.

Every effort to assist you in making a convenient appointment has been made; if you must reschedule please notify us **2 business days prior** to your scheduled appointment. Please take into account that our office is open from Monday to Thursday.

Time is valuable for both you and us. If a confirmed appointment is broken without proper notice, there will be a **\$50.00 broken appointment fee**.

If an appointment has been scheduled, please be on time, since ample time has been set for your treatment. If you are **ten minutes** late, your appointment may be rescheduled.

Minors **under the age of 18** with scheduled appointment must be accompanied by a parent or legal guardian.

### THANK YOU,

*By signing, I confirm that I have read and understand the office policy of this practice. In cases where payments are being accepted directly from the insurance company, I authorize payment of dental benefits to the dentist providing the professional services rendered. I also authorize the release of any dental information necessary to process my claims.*

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date