

Family & Cosmetic Dentistry of Nashville

4/09

Ralph J. Sharow, DMD

2285 Murfreesboro Road, Suite 210

Nashville, TN 37217

Visit our "2009" Web Site to view our Monthly Dental Health Guide, Monthly Patient Education and **sign up for our free monthly News Letter at: WWW.DrRalphSharow.com**

Write to us at info@DrRalphSharow.com

(615) 366-7154

fax:(615) 399-9702

Payment Insurance Appointment Policy

To: _____ (Print Name)

In order to serve you better we request that you read the following information carefully. Sign your name acknowledging that you understand our payment & insurance policies.

As a courtesy, we will file your dental insurance. Dental insurance is not intended to pay your dental bill in its entirety. It is strictly an aid to help with dental expenses. The patient's estimated portion is due the day of service. Sometimes your dental treatment may not be a covered expense with your dental insurance plan. You have the right to request the proposed treatment regardless if it is not a covered expense under your insurance plan. This is called "Optioned Service." However, you will be responsible for the difference that the insurance will not cover at the time of service. If we have not heard back from the insurance within 60 days after the claim has been filed, the balance may become the patient's responsibility. Balances left after insurance clears may be put on your credit card or Care Credit on file with us. In the event the balance of this account or any portion of the account balance is turned over for collection, I agree the undersigned will be responsible for collection cost and/or legal costs including attorney fees which may increase my balance substantially. I authorize this facility and/or it's agent to verify my employment at any time. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance. I further understand that a \$ 10.00 monthly service charge will be added to any overdue balance. Payments are due upon receipt of statement. If your child is attending college full time, insurance requires us to have written proof of payment by the semester or 12 or more credit schedule. This must accompany insurance claim. It is the patient's responsibility to keep our office updated with current home address. Home, work & cell phone numbers. Current employer, address & contact phone number. Plus updated insurance and credit card information.

**** WE SCHEDULE BY APPOINTMENT & BLOCK OUT THAT TIME FOR YOU ****

We have a 48 hour cancellation policy. Appointments missed without a 48 hour notice may be subject to a \$ 35 charge. Remember, appointment confirmation is a courtesy. We may not be able to contact you the evening before and *you* are still responsible for your own appointment. No show appointments will have a minimum fee of \$75.00.

Multiple missed and or no show appointments will cause discharge from our practice. We can no longer see patients who continue to disrespect our schedule. Please understand, other patients are waiting for these appointments and the doctor's available time is very limited. *Most appointments are 1 hour or less. For major cases requiring large blocks of time, deposits equaling 20 % of your portion of the procedure (s) of that visit, (minimum of \$ 100), will be required at the time of scheduling the appointment and is applied to your dental treatment. All procedures are billed out the day they are started and in certain cases are not completed the same day. You are still responsible for that procedure.*

At the request of the patient or another Doctor, (along with a signed release), we will be happy to forward a copy of your dental xrays. However, there is a \$25 duplication fee. This is the law. All Dentists are required to maintain your records and xrays for 7 years after inactivity.

We accept the following forms of payment: Cash, Check, Visa, Master Card, Discover, American Express, Debit Cards, *Care Credit* (and others), which may have extended interest free program periods.

We do not make monthly payment arrangements. We offer a program called "Care Credit," as stated above. We have additional information on this program. This can be obtained in minutes with approved credit. **I have read the above policies and agree to abide by them.** Checks received may be converted for electronic capture.

Signed: _____ Date: _____

The benefits of a happy and healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health and aesthetics.