Maxson Dental

<u>Missed Appointment Policy</u>

In order to provide quality care to our patients and minimize waiting for appointments, our office has adopted the following policy regarding missed appointments.
I understand that if I should fail to keep scheduled appointments within a twelve (12) month period, it may be necessary for me to make arrangements to receive my dental care elsewhere.

I further understand that the procedure works as follows:

- A **<u>telephone call must be made 24 hours prior</u>** to my scheduled appointment to avoid a missed appointment fee. Emails and social media cancellations are not acceptable
- For the **<u>FIRST</u>** missed appointment, a reminder letter will be sent indicating that a scheduled appointment has been missed
- If a **<u>SECOND</u>** appointment is missed a non-refundable fee will be accessed as follows

  Hygiene –$75

  Doctor - $ 75 per hour of the scheduled treatment. Ex. 3 hr appt = $225
- If a **<u>THIRD</u>** appointment is missed the patient and all associated with the account will be <u>dismissed</u> from the practice

Initial

<u>Payments/Insurance Benefits</u>

Your dental benefit program can help you with achieving and maintaining optimal oral health.
We are happy to serve as a resource for you and we will be glad to assist you in obtaining the maximum benefits specified in your contract, without compromising our standard of care for you.

1. Your dental benefit program is a contract between you and the insurance company.
   We are not a party to that contract.
2. Not all dental services are a covered benefit in all contracts.
3. We are happy to submit claims on your behalf for services rendered.
4. You are responsible for the fees for all services rendered to you **at the time of service**.

I have read and understand the above information. **<u>If for any reason my insurance plan does not cover what has been estimated I am responsible for paying the remaining balance in full</u>**.

Initial

<u>HIPAA</u>

(HIPAA - Notice Of Privacy Practices) I have read/reviewed and/or received a copy of this office's (HIPAA). I consent to the disclosure of my (PHI) Personal Health Information. (You may ask for a copy to review).

SIGN: Patient's and/or guardian's signature