

DR. RENGER & DR. KIVETT – OFFICE POLICY

PAYMENTS:

PAYMENT FOR TREATMENT IS DUE AT TIME OF SERVICE. ANY SPECIAL ARRANGEMENTS FOR PAYMENT MUST BE MADE PRIOR TO TREATMENT WITH YOUR DOCTORS' FINANCIAL COORDINATOR OR OFFICE MANAGER.

DENTAL INSURANCE:

OUR OFFICE FILES INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS. EMPLOYERS OFFER DENTAL BENEFITS TO HELP EMPLOYEES PAY FOR A PORTION OF THE COST OF THEIR DENTAL CARE. DENTAL PLANS ARE DESIGNED TO SHARE IN THE COST OF YOUR DENTAL CARE, NOT TO COMPLETELY PAY FOR THOSE COSTS. ALMOST ALL DENTAL BENEFITS PLANS ARE THE RESULT OF A CONTRACT BETWEEN THE PLAN SPONSOR AND THE THIRD-PARTY PAYER. **THE AMOUNT YOUR PLAN PAYS IS DETERMINED BY YOUR EMPLOYER WITH THE INSURER.** YOUR DENTAL COVERAGE IS DETERMINED NOT BY YOUR DENTAL NEEDS – BUT BY HOW MUCH YOUR EMPLOYER CONTRIBUTES TO THE PLAN. OUR OFFICE CAN **ONLY ESTIMATE** INSURANCE COVERAGE FROM INFORMATION PROVIDED BY YOUR INSURANCE CARRIER. YOUR INSURANCE MAKES THE FINAL PAYMENT DETERMINATION ON EACH CLAIM FOR TREATMENT. ANY PORTION OF CO-PAYMENTS AND/OR OUT OF POCKET EXPENSES, MUST BE PAID FOR AT THE TIME OF DENTAL SERVICES.

CANCELATIONS, RESCHEDULING & NO SHOWS

ANY CANCELATIONS OR RESCHEDULING SHOULD BE DONE AS SOON AS THE PATIENT BECOMES AWARE OF ANY CHANGES. OUT OF COURTESY TO OUR OTHER PATIENTS AND DENTAL TEAM, WE REQUEST A **FULL BUSINESS DAY MINIMUM NOTICE**. THIS POLICY ALLOWS OUR OFFICE TO PROVIDE TIMELY SERVICE TO ALL OF OUR PATIENTS THAT NEED APPOINTMENTS. IF A PATIENT DOES NOT CALL TO CANCEL OR RESCHEDULE AN APPOINTMENT, OR DOES NOT SHOW, IT IS POSSIBLE THAT THE PATIENT MAY OR MAY NOT BE ELIGIBLE TO RESCHEDULE FOR A FUTURE APPOINTMENT. **A \$25 OFFICE FEE PER EACH MISSED HOUR WILL BE CHARGED. OUR OFFICE IS OPEN FOR BUSINESS MONDAY THROUGH THURSDAY 7AM TO 5PM, THANK YOU.**

I ASSUME THE RESPONSIBILITY OF UPDATING ANY CHANGES IN THE "PATIENT INFORMATION" SHEET AT FUTURE VISITS. I CONSENT TO THE DENTAL TREATMENT DEEMED NECESSARY BY DR. RENGER & DR. KIVETT WITH THE UNDERSTANDING OF A MUTUAL AGREEMENT BEFORE TREATMENT BEGINS. THIS OFFICE WILL ASSIST IN FILING DENTAL INSURANCE WHEN ELIGIBLE, BUT I UNDERSTAND I AM RESPONSIBLE FOR ALL COST OF COLLECTION FEES, INCLUDING REASONABLE ATTORNEY FEES.

DATE: _____ SIGNATURE: _____