proudsmiles
A Health-Centered Dental Practice
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Important Office and Financial Policy

The team at Proud Smiles sincerely appreciates your choice in entrusting us with your dental care needs. It is truly an honor to serve you, and we eagerly look forward to the opportunity to do so. Our dedication is firmly rooted in providing you and your family with the highest level of care while nurturing a strong provider-patient relationship.

We recognize the importance of clarity regarding both office procedures and financial responsibilities in fostering this relationship. If you ever have any questions or concerns regarding our fees, policies, or your responsibilities, please do not hesitate to reach out to our office. Your satisfaction and comfort are paramount to us, and we are committed to ensuring that your experience with us is seamless and satisfactory.

Please read each policy and sign the bottom of the page acknowledging you have read and understood our policies.

Dental Insurance:

It is imperative to complete personal information and provide a copy of your *current* insurance card prior to your visit to ensure accurate billing. Once your dental benefits have been verified, we will prepare AN ESTIMATE of your patient portion. Payment of your estimated portion is expected at the time of services. Your insurance may not pay as estimated and you may have a balance due after insurance payment is received. Some insurance policies will reimburse patients directly and require you to pay your balance in full at the time of service. **If the incorrect insurance is provided, there is a $45 re-filing fee.**

Our office can NEVER guarantee coverage for any services provided. Insurance companies will not guarantee benefits until a claim is received. It is important as a patient you educate yourself about your individual benefits. You must realize your insurance is a contract between you and the insurance company and/or your employer. While we maybe a provider of service, we are not party to the contract and are considered an out-of-network provider. If you are unsure of your coverage benefits, call the customer service number on your insurance card.

Payment Options:

For your convenience, we accept American Express, Visa, Mastercard, Discover, & CareCredit. Individual financial arrangements can be made to assist you with your budget prior to initial treatment. ***Payment of your estimated patient portion, co-pays, deductibles, and prior balances are due at the time of service.***

Appointments:

We appreciate your promptness and consideration in not changing your scheduled time with the doctor and/or hygienist. Arriving more than 15 minutes after your appointed time is defined as late and may need to be rescheduled. However, **if you need to change, reschedule, or cancel an appointment, we require a 2-business day notice to avoid a fee.** Changes to an appointment without a 2-business day notice or a no-show will be subject to a cancellation fee based on an hourly rate appropriate for your visit and could range from $75.00-$500.00. All fees must be paid before any additional appointments can be scheduled. Repeated changes, lateness, short-notice cancellations, or no-shows are disruptive to the optimal delivery of your care and also deprive other patients from receiving needed treatment. In the event of three missed appointments, the practice reserves the right to discontinue your care at its discretion so that we can provide care to other patients. **Cancellation fees cannot be billed to insurance and will be your responsibility.

An appointment of 2 hours or longer will require a 30% deposit of total treatment. Should you cancel without a 2-business day notice, a cancellation fee will be deducted from this deposit.

Past Due Accounts and Returned Checks:

A 90-day overdue account will be turned over to a collection agency. Please be aware that a $50.00 processing fee as well as a fee of 40% of your balance will be added to your account.

For checks returned to us as unpaid by your bank will be charged a $35.00 fee.

I have read and fully understand Proud Smiles statements and policies listed above.

Patient Name: _____

Patient/Guardian Signature: _____ **Date:** _____