CORINTH DENTAL CARE
OFFICE AND FINANCIAL POLICY

MINOR CHILD: It is required that a legal guardian accompany their minor child **(Age 17 and under)** to each appointment unless we have a consent signed and payment arrangements have been taken care of prior to the appointment.

________(initial here)

PAYMENT: Payment in full is due at the time of service. Our office is committed to helping patients maximize their dental plan benefits. We make every effort to help estimate insurance benefits. As a courtesy to you, we will file claims to all dental insurance companies. Please keep in mind that **your insurance policy is a contract between you and your insurance company**. Corinth Dental Care is not a party in that contract. We offer several payment options: Cash, check, credit card (Visa, Discover, and MasterCard).

________(initial here)

PAST DUE ACCOUNTS: All balances remaining on an account are due within 30 days of the first billing statement. Balances over 90 days will begin to accrue a monthly 1.5% finance charge. If your account is sent to collections for untimely payment, you may be charged a fee of 33.33-45% as well as attorney fees and costs.

________(initial here)

RETURNED CHECKS: There is a $20 fee for checks returned due to insufficient funds. We require immediate payment in cash, money order, or credit card, upon notification of insufficient funds.

________(initial here)

CANCELLATION/NO SHOW POLICY: We understand that there are times when you must miss an appointment due to emergencies, or obligations from work or family. However, when you do not call to cancel an appointment or do not give sufficient notice, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 business hours in advance it is considered a "failed" appointment.** After a second occurrence, you will be charged a $50 fee. A third failed appointment may be regarded as termination of relationship, and/or dismissal from the practice.

________(initial here)

I have read and accept the terms and conditions of the above policies. I authorize **CORINTH DENTAL CARE** to file insurance on my behalf for my treatment. I also authorize **CORINTH DENTAL CARE** to release information, to include medical/billing information, to referred specialists, insurance company or guarantor of this account.

I understand that I am to be financially responsible for any balances remaining on this account for services not covered by insurance.

______________________________	______/_____/_____
Patient's Name	**Patient's Date of Birth**

______________________________	______________________	______/_____/_____
Patient, Parent, or Guardian Signature	**Relationship to Patient**	**Today's Date**