SOUTH MAIN DENTAL
FAMILY FRIENDLY DENTISTRY

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Appointment Policy

Thank you for choosing South Main Dental as your oral healthcare provider. Your scheduled appointment time is specific to you and your needs. Missing your appointment time slot places undue burden on our office, schedules, and staff.

1. For your convenience, we will call with an appointment reminder, and send you an email and/or text message reminder of your appointment, if you provide us with your email address and cell phone number.
2. We require a minimum of 24 hours' notice to Cancel or Reschedule an appointment.
3. Missed/Failed Patients and patients who cancel with less than 24-hours' notice may be subject to future scheduling limitations.
    a. A ***Cancelled Appointment*** is when a patient notifies the office less than 24-hours before their scheduled appointment time.
    b. A ***Missed/Failed Appointment*** denotes a patient/family who fails to show and notify our office.
4. **Cancelled Appointments:**
    a. *First Cancelled Appointment:* Life happens and we understand. We will gladly reschedule your appointment for you if something comes up last minute.
    b. *Second Cancellation:* We will remind you of our policy and that we may restrict your future scheduling.
    c. *Third Cancellation:* You will only be able to schedule future appointments during the same day or week.
5. **Missed/Failed Appointments:**
    a. *First Missed/Failed Appointment:* We allow for one Missed/Failed Appointment, as we understand life happens.
    b. *After a second Missed/Failed Appointment*, patient will be restricted to same day or same week scheduling.

_____(Pt Initial)

Office Financial Policy

Our goal is to provide you with the highest quality dental care at a reasonable fee. Please understand that payment of your bill is considered part of your treatment.

1. You are the responsible party for 100% of the payment for services. As a courtesy we will accept assignment of benefits upon verifying coverage with your insurance company. If you are not able to provide us with the information necessary to verify your insurance coverage, then you will be responsible for full payment at the time of service. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. If your insurance company has not paid your account balance within 60 days of treatment the balance will be automatically due and payable by you. _____(PT Initial)
2. If you have insurance, ***you are required to pay your estimated portion of treatment on the day of service***. We do our best to estimate treatment costs and insurance coverage but cannot guarantee our estimated service fees and your insurance company's payout. _____ (PT Initial)
3. For your convenience we accept cash, personal checks, money orders, Visa, MasterCard, American Express, Discover Card, Cherry, Care Credit and Sunbit. We offer a discounted professional courtesy on payments made with checks or cash on the day of service for patients without insurance. This does not apply to debit or credit cards.

4. Patients that currently have a balance with our practice will be asked not to incur any additional dental expense. For new treatment to begin, the previous balance will need to be paid in full.
5. To avoid increased fees to all patients, all balances that are older than 90 days will incur a 0.5% per month interest charge (6% per year).
6. In the event that any unpaid balance is placed for collections and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, a fee of 30% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly by South Main Dental, PA to collect amounts owed under this agreement such as court costs, interest, late fees, etc. The fee of 30% and the additional costs and charges listed above reflect the actual costs incurred by South Main Dental, PA to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement. All accounts turned over to collections will be closed in our office and those patients may be asked to seek treatment elsewhere.
7. Emergency patients who are not of record shall pay for services when they are rendered. We will assist in filing a claim with your insurance company.
8. In situations where treatment requires more than 1 visit to complete (ex. Crowns, bridges, root canals, etc.) a down payment will be due at the first visit of at least 50%. Any remaining patient portion due shall be completed by final appointment.
9. Regarding minor children, the responsible party is the parent/guardian who brings the minor to their first appointment.
10. We reserve the right to collect co-payments and/or a deposit at the time of scheduling an appointment for any patients with a cancellation or no-show history.
11. For your convenience, we offer financial assistance through Cherry, Care Credit or Sunbit, who are individual companies not affiliated with our practice. Payment arrangements must be made prior to beginning treatment. Our staff is happy to assist you to help completing the application.
12. Due to the complex nature of dentistry, it is possible that changes in your treatment plan may occur during treatment process. As a result, additional costs may be incurred for which you will be responsible. Dr. Pierson and/or Dr. Crook will make the most accurate treatment plan possible at your initial visit, given the information that she/he has at the time, in order to minimize the chance of additional fees.
13. There will be a $35.00 return fee charge for all returned checks. After that, we will no longer be able to accept checks as an acceptable form of payment. Returned checks not paid in full (including the returned check fee) within five days will incur a 0.5% per month (6% annual) interest charge and the account may be turned over for collection. Any checks returned for being written on a closed account will be forwarded to the State Attorney and the account will be immediately sent to collection.

Thank you again for choosing us as your dental care provider. Please let us know if you have any questions or concerns.

Signature: _____

Printed Name: _____ Date: _____