Financial / Appointment Policies

TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Thank you for choosing ComfortCare Dental to provide your dental care. We will do our best to continue to earn your confidence. We are dedicated to providing you with the most comfortable and technically up-to-date dental care.

When you have an appointment with ComfortCare Dental, we will do our best to see you promptly. We feel that your time is just as important as our own. We understand that late arrivals to appointments are occasionally unavoidable, but late arrivals can also cause problems for other scheduled patients.

Late Arrival Policy
If you arrive more than 10 minutes late, we will evaluate our schedule to determine if you may be seen. In some instances you may be asked to reschedule. If you need to change an appointment, we require at least 24 hours notice, (a Monday appointment would have to be changed by Friday).

A BROKEN APPOINTMENT could incur a charge. If you continue to break appointments ComfortCare Dental reserves the right to dismiss you from our practice.

Late Payment Fees
A monthly interest fee of one and one-half percent of the balance will be applied to accounts with balances not paid within thirty (30) days. ComfortCare Dental is not responsible for disputed or disallowed claims or for resubmission of claims that have been disallowed. If it becomes necessary to turn matters over to an attorney, patient agrees to be responsible for all collection costs and reasonable attorney fees.

Insurance Reimbursements
ComfortCare Dental's staff will work with your insurance company to ensure that you receive the maximum allowable benefits from your policy. Please remember that we have no control over the benefits of your plan. Our claims and codes are approved by the American Dental Association and your claim will be sent out promptly.

For your convenience, we have two ways to handle your insurance claims. **Please read and initial below your choice.**

A) I wish to have my insurance company pay their portion to ComfortCare Dental. I acknowledge that any portion of fees not paid by my insurance company, as well as claims not paid within 60 days, are my responsibility and I will pay the balance. I hereby assign benefits to ComfortCare Dental.

I choose option A: __________

B) I choose to pay the entire fee myself and have my insurance company reimburse me. I understand that the entire fee must be paid by me before the claim can be filed.

I choose option B: ____________

I have read and understand the financial and appointment policies of ComfortCare Dental.

Patient or Guardian Signature: ____________________________________

Patient Name: ____ Date: __________________________