

~~Kingman Family Dentistry~~

Office Policies

Financial Agreement – I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account in accordance with the regular rates and terms of this office. If my account is referred for collection, I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 55% of the debt, and all costs and expenses, including reasonable attorneys' fees, incurred in such collection efforts. I understand that if I have not paid my balance in a timely manner, a finance charge may be applied to my account.

Insurance Policy-This office may release records pertaining to my treatment to my insurance company, or other 3rd parties involved in the claims process. I also understand that while Kingman Family Dental may assist me by filing claims, ultimately it is my responsibility to ensure all my information is current and correct. Estimated insurance portions are not a guarantee of payment. I am responsible for any remaining balance after insurance.

Cancellation Policy – Please note that we do require a 24hr. cancellation notice. If notice is not given, \$25 may be charged to your account. This is to cover the time that has been lost. If you recurrently fail to give notice, a deposit may be required before we will schedule your next appointment. For larger appointments, a deposit may be required to schedule initially. Upon your scheduled arrival, the deposit will be applied towards the fees for that service.

I have reviewed a copy of this office's Notice of Privacy Practices.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedures that may follow. I hereby consent to any proposed dental treatment.

Once you have read, and understand all policies above, please sign below.

Patient Name

Date

Witness