

NOTE TO OUR PATIENTS

- ❖ **AS A COURTESY WE WILL FILE DENTAL INSURANCE CLAIMS FOR OUR PATIENTS. THIS DOES NOT TRANSFER YOUR FINANCIAL OBLIGATION TO YOUR INSURANCE COMPANY. IF YOUR INSURANCE PLAN HAS A CO-PAYMENT, YOU ARE REQUIRED, PER THE CONTRACT SIGNED WITH YOUR INSURANCE COMPANY, TO PAY THAT CO-PAYMENT AT THE TIME OF YOUR VISIT. HOWEVER, THIS DOES NOT GUARANTEE THAT YOUR INSURANCE WILL PAY FOR THE BALANCE. IF YOUR CLAIM IS NOT PAID, AND YOU FEEL IT SHOULD HAVE BEEN, PLEASE CONTACT YOUR INSURANCE COMPANY DIRECTLY.**

SIGNATURE _____ DATE _____

- ❖ **MISSED APPOINTMENT FEE: THE SECOND TIME A PATIENT DOES NOT SHOW FOR AN APPOINTMENT, OR CANCELS WITH LESS THAN 24 HOURS NOTICE, A \$35.00 FEE WILL BE CHARGED. THIS FEE MUST BE PAID BEFORE A NEW APPOINTMENT IS SCHEDULED.**

SIGNATURE _____ DATE _____

- ❖ **FOR YOUR BENEFIT, WE ARE AN AMALGAM-FREE OFFICE! THIS MEANS WE ONLY PLACE THE TOOTH-COLORED BONDED FILLINGS. IF YOUR INSURANCE ONLY ALLOWS THE AMALGAM FEE, YOU WILL STILL BE RESPONSIBLE FOR ANY AMOUNT YOUR INSURANCE DOES NOT COVER.**

SIGNATURE _____ DATE _____

THANK YOU,

FAMILY CARE DENTISTRY