FINANCIAL POLICY

COLVIN TAO FAMILY DENTISTRY

Welcome! Thank you for choosing us as your dental healthcare providers. Our goal is to make you and your family feel welcomed and valued while providing you with optimal dental care. We encourage you to ask questions and to be involved in treatment decisions, while we help educate you about your oral health and the importance of prevention. This form is to inform you of our financial policy.

APPOINTMENTS: To serve you better, we try to maintain an efficient appointment system. However, the cost of providing care increases greatly when patients fail to keep scheduled appointments or cancel at the last minute. We require at least 24-hour notice to cancel an appointment. If you fail to notify our office, before the 24-hour courtesy window, your account will be charged $50.00 per our NO SHOW/CANCELLATION policy.

POLICY: If you accrue 3 missed appointments without 24-hour notice or no shows, regretfully, this will result in your dismissal from our practice.

INSURANCE INFORMATION: All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. As a courtesy to our insured patients, Colvin Tao Family Dentistry office administration will offer to send a pre-determination to your insurance company so you may know in advance the estimated amount covered by your insurance plan. We will also submit claims to your insurance company. In order to provide this service, we will need your insurance card and/or insurance policy at or prior to your dental visit. We will also need your insurance card and/or policy when you have any changes to your insurance. It is ultimately your responsibility to know your own insurance benefits, as there are so many varying policies it is impossible for us to be familiar with them all.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy will also cover your dependent children who are patients of the practice.

_____ _____

Printed Name of the Patient date

_____ _____

Patient Signature date

_____ _____

Office Representative Signature date