FREDERICK COSMETIC & FAMILY DENTISTRY OFFICE POLICIES

We appreciate the opportunity to provide you with dental services. Our staff is dedicated to seeing that your dental visit is a pleasant one. We have outlined our office policies below. We would like to welcome you to Frederick Cosmetic & Family Dentistry. Thank you for the trust you place in us by choosing our office for providing your family's dental care. We gladly welcome the referral of your friends and co-workers to our family of dental patients. We are committed to providing quality dental care to patients of all ages and offer comprehensive services for your entire family.

It is our primary goal to provide quality personalized dental care at reasonable rates. In an attempt to contain the cost of dental healthcare, our office has adopted a policy of payment due when services are rendered. However, you are responsible for the fees. Your deductible or any other balance not covered by your insurance company is due at the time of treatment. We will attempt to determine your co-payment as accurately as possible. Any overpayment will either be refunded or credited to your account. Any underpayment will be billed during the normal monthly cycle. Please remember to bring your insurance information with you and we will be happy to submit the claim to the insurance company for you. If you do not have the information, you may be asked to pay for the rendered services and have the insurance company reimburse you directly.

Our office accepts cash, personal checks and major credit cards. Payment plans are available. There will be a service charge for any checks returned from the bank. All patients requiring extensive services will receive an estimate before treatment begins. Our first consideration is always your dental health. If you have a problem, please let us work with you to reach a mutually agreeable solution.

We welcome new patients and are available on an appointment basis Monday through Friday. We make every effort to respect our patient's time and to remain on schedule. Therefore, we request that you extend the same courtesy to us. Since we reserve time for your appointment that others may need, if you cannot keep an appointment we ask that you please give us 24 hours notice. Appointments cancelled without 24 hours notice may be subject to a $45.00 per 30 minute charge. This fee is the patient's responsibility since the insurance company cannot pay for a service that is not rendered. Also, for inclement weather, our office follows the Frederick County Board of Education policy for opening and closings. We follow the infection control guidelines of the American Dental Association and maintain the most up-to-date methods of sterilization for you and your family's protection. We know that emergencies can arise and we will do our best to respond to your dental problems promptly. It is our immediate concern when you are uncomfortable.

PATIENT TREATMENT CONSENT

I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform recommended treatment and therapeutic procedures to include administering medications as prescribed by Dentist(s) and mutually agreed upon by me. In accordance with MD Record Law, section 4-304 any request for a release of patient records to a new dentist must be in writing and a $25 fee may be required. I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy (s) to the Dentist. This form also authorizes the Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist (s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary ands/or requested. I agree to be responsible for payments of all services rendered on my behalf or my dependents. If my account becomes assigned to a collection agency, I agree to pay all collection fees, court costs and attorney fees I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1 ½ % per month.

(SEAL) ____ Date: _____/____/____

Patients Signature