

BROWNSBURG DENTAL GROUP, P.C. OFFICE POLICIES

Thank you for choosing us as your dental care provider. Our goal is to provide you with quality dentistry in a warm and friendly atmosphere. Your comfort and satisfaction are of the utmost importance to us. Therefore, if you ever feel uncomfortable or dissatisfied in any way, please feel free to let us know so we may address your needs and concerns.

The staff of Brownsburg Dental Group is dedicated to complying with regulations concerning universal precautions regarding sterilization, disinfecting, and barrier techniques, thereby ensuring patient safety, as well as our own.

We are a fee-for-service office and expect payment at the time of service. **ALL CO-PAYMENTS AND/OR PORTIONS NOT COVERED BY YOUR INSURANCE ARE EXPECTED AT THE TIME OF SERVICE.** We will accept payment by cash, check, or credit card. Please ask us about special financial arrangements prior to scheduled appointments.

We will always try to inform you of your charges prior to each visit. These are only estimates, not quotes. Verification of benefits is not a guarantee for payment, which will be determined when a dental claim is submitted. We will submit your insurance forms as a courtesy and with this, you, as the insurance subscriber, are ultimately responsible for what your insurance does not cover. If your insurance company does not pay within 60 days, you are then responsible for paying us and collecting from them. In the event of payment delinquency, you will be required to cover all expenses associated with collection proceedings.

In order to be seen on time, we request you arrive for your appointment on time, however, please keep in mind that we are obligated throughout the day to see patients on an emergency basis, which sometimes causes us to fall behind schedule. If this occurs, your patience is appreciated. If this is too much of an inconvenience, please feel free to reschedule your appointment. We understand that your time is as valuable as our own.

We require a 24-hour notice to cancel or reschedule an appointment. Failure to give this notice and/or failure to keep your appointment may result in a broken appointment fee equal to the fee associated with your reserved appointment. This fee must be paid before the next appointment. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our office policies. Please let us know if you have any questions or concerns.

I have read the office policies and understand and agree to them.

X _____ Date: _____
Signature of Patient or Responsible Party