Edward E. Lancaster, III, DMD

FAMILY DENTISTRY

Thank you for choosing our practice. We are committed to providing the best possible care. The following information is provided to avoid any confusion regarding payment for our professional services. Please sign below that you have read and agree with this Policy.

Dear Patient:

Payment is **EXPECTED** at the time services are rendered unless prior arrangements are made. If you have dental insurance, we will be happy to file your claims for you. However, it is your responsibility to know your benefits and to notify this office of any changes to your insurance coverage, and your co – payment and deductible is **EXPECTED** at time of services. Your insurance policy is a contract between you and your insurance company. If after 45 days your insurance has not paid, you will be responsible for the entire amount. Please provide us with all the **Necessary and Correct dental information** at the time of your visit. Any requests from your insurance company only delays payment. A charge of **$ 10.00** will be added to refile corrected insurance claims.

If a patient is a minor (18 years old and younger), the parent or guardian is responsible for payment of the account. If parents are divorced, the adult who brings the child to the appointment is responsible for applicable fees.

We accept most **credit cards, bankcards, cash & checks.** However there will be a **$35.00** charge for all checks returned from the bank.

We request **24** hour notice if you need to cancel an appointment in order that we might give the appointment to someone who is waiting to be seen. A charge of **$25.00** will be added to your account for failure to keep an appointment. We understand emergencies arise, however **PLEASE CALL** us as soon as possible if you need to reschedule an appointment.

If your account becomes **delinquent by more than 90 days** and we deem it necessary to involve a **THIRD PARTY** into the collection effort, you may be subject to a penalty equal to **30 %** of the unpaid balance.

I have read, understand and agree to the above Payment Policy. I understand that any charges not covered by my insurance company are my responsibility.

Thank you,

Edward E. Lancaster III, DMD and Associates

Signature of Responsible Party _____

Witness _____ Date _____

REV : 12/10