Appointments

Our staff goes to great lengths to provide the quality of care that we feel each of our patients deserve. When we schedule your appointments, we follow carefully planned protocols to maintain that goal. As a courtesy, our staff will call at least 48 hours in advance to confirm each of your appointments. If we are not able to reach you or you receive a voicemail, please call our office to verbally confirm your appointment time. This will help us be better prepared for your arrival. **Please understand that we may not be able to hold your appointment time if we are unable to confirm your appointment.**

We do respect our patient's schedules and we asked that you would also have respect for our schedule and the schedule of others. Late arrivals cause us to run late for other patients. Please understand that arriving after your appointment time may result in the rescheduling of your appointment. We do understand unexpected events and emergencies can happen. Please let our office knows as soon as possible that you can not make your appointment time. If it does not interfere with other patient's schedule we will be happy to accommodate you.

We do ask for 48 hours notice to reschedule or cancel an appointment. Multiple rescheduled or cancelled appointments may result in additional charges that would need to be paid prior to scheduling future appointments. The minimal charge for lack of notice will be $50 or an hourly rate to help defer some of the overhead expense associated with not having a patient scheduled in your time slot. Thank you for your understanding and the understanding of others. **After two broken or missed appointments, the dentist reserves the right to discontinue any additional treatment.**

Financial Agreement

Our goal is to offer you payment options to finance the care you need to maintain good oral health while staying within your budget. This practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or with a credit card at the time services are performed.

Credit Cards
For your convenience, we accept MasterCard, Visa, Discover and CareCredit.

Extended Payments
For patients who desire a monthly payment plan, we have made arrangements with CareCredit. There are no application fees, no down payment is necessary, and the loan can be **interest-free***. Applications are provided by our office manager and approval is provided very quickly, usually within 30 minutes.*

Dental Insurance
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy, we will file your insurance, speak on your behalf to the insurance company and accept any assignment of benefits that your insurance company will allow. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We will estimate your patient portion by considering deductibles, maximums and the knowledgebase provided by your insurance company. Please understand that your insurance policy is a contract between you and your dental insurance company. The insurance company will not guarantee payment therefore we ask that all patients be directly responsible for all charges. If for any reason your insurance company pays less than our estimate, you are responsible for the unpaid balance. Accounts with balances over 30 days will be turned over to a collection agency. For all patients under the age of 18, the legal guardian presenting the patient for treatment is responsible for all payments to Divine Dentistry. This office does not participate in any agreements between parents or other parties. We will be happy to provide receipts and ledgers for any charges and payments for your cause.

All Patients and Responsible Parties
I further agree that I shall be billed unless objected to, by me, in writing, I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Authorization and Consent

I agree that I have filled out these forms with the intent of honesty and I agree that it is my own responsibility to update any changes in my medical history and or conditions with each dental visit.

General Consent for Treatment

I agree and consent to a dental examination by dentist(s) practicing under the name Divine Dentistry. I understand that additional diagnostic procedures and treatment may be recommended and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.

Release of Information

I authorize Divine Dentistry to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Divine Dentistry.

Photography Release

I authorize Divine Dentistry to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options (as you may be shown photographs for the same reason).

My signature acknowledges that:

I will be responsible and update any information on these forms with each dental visit.
I understand the office policy regarding Appointments.
I understand and will comply with the office Financial Policy.
I understand and agree to the General Consent to Treatment.
I authorize the Release of Information.
I assign my insurance benefits payable to Divine Dentistry.
Photographs taken of me may be shown to other patients or in advertisements.
I have been offered a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient, Parent or Guardian **Date**