Understanding Your Dental Benefits/ 24 Hour Cancellation Policy

We value your time and reserve appointment times based on the needs of each patient. By providing us with enough notice for rescheduling your appointment, we are able to open the reserved time up to other patients needing to be seen. This policy makes scheduling convenient for patients and allows us to begin and end your appointments on time.

We kindly ask that you provide a 24-hour notice if you must cancel an appointment. Without a 24-hour notice, there will be a **$25.00 charge** added to your account. This will not be covered by your insurance company.

Dental benefits have become an integral part of health care planning for many families. As the number of patients covered by dental plans has increased, certain assumptions have become evident. I would like to make the principles of my practice, as well as the types of service and care I provide my patients, very clear:

- Our fees are based on the overhead involved in the practice, the treatment plan selected, and the time it takes to provide you with the necessary dental care.
- The type of treatment you need and receive is based on my professional judgment and not on whether you are covered by a dental benefits plan. I am more than happy to discuss a treatment plan's advantages and disadvantages with you in order to accommodate you, not an insurance company, in the health care decision-making process.
- If treatment is recommended, our office will complete and present a treatment plan to you showing what treatment is recommended, the order in which the treatment is recommended to be rendered, the fees our office charges for the services needed, and an estimation of what your dental plan may cover. **This is only an estimation of your dental benefits.**
- The amount estimated to be your "out of pocket" on the treatment plan will be **due when services are rendered.**
- As a courtesy to you, our office will complete the dental claim form and send it to your insurance company.
- Your dental plan holds the right to deny or pay a different fee amount for services rendered. This may result in a further payment due to our office. **This balance is YOUR responsibility.**
- Pre-authorizations can be sent for the insurance company to review. However, please remember that the financial obligation for dental treatment is yours.

No question is too small for you to ask, whether it is about your treatment, benefit plan, or statement. Stop in or call us at (937) 738-7610 any time you have a question. We are here to help you and provide you with the best dental care possible!

_____ **I have read and understand the above information. I have been given a chance to ask any questions regarding my individual insurance policy.**

_____ **By signing below I agree that any balance due after insurance payment is my responsibility and not that of Cromwell Dental Care.**

Printed Name: _____

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

** You May Refuse to Sign This Acknowledgment**

I acknowledge that I have read a copy of the Notice of Privacy Practices from Cromwell Dental Care. I also acknowledge that I was given the option to receive a copy of the Notice of Privacy Practices for my own personal records.

Patient/Guardian Signature_____