

FOY DENTAL CARE OFFICE POLICY

Welcome to our practice! We are dedicated to performing high quality dental care using the latest dental technology advancements in a caring and friendly environment; providing our patients with a uniquely positive dental experience. We thank you for choosing to be a part of our dental practice and welcome your referral of family and friends.

APPOINTMENTS

- ❖ **Once an appointment is made, please remember that this time is reserved specifically for you.**
- ❖ **If you must change your appointment time, Foy Dental Care requires a 48 hour (at least two full business days) notice on any cancellation or re-scheduled appointment. (Legitimate emergencies are exceptions.)**
- ❖ **We reserve the right to assess a fee for the time reserved for an appointment in which two-business day's notice is not provided to our office. This fee can range from a minimum of \$25.00 to \$125.00 per half hour, based on the complexity of the services to be performed at the time of your visit.**
- ❖ **Cancellation or appointment changes must be handled by a staff member and not via our voicemail system or email.**

INSURANCE

- ❖ **If you have dental insurance coverage, Foy Dental Care will file your dental claims as a courtesy to you.**
- ❖ **Please be aware that all professional services rendered are charged directly to the Patient/Responsible Party and the Patient/Responsible Party is personally responsible for payment of fees.**
- ❖ **We DO NOT render our services on the basis that insurance companies will pay all of our fees.**
- ❖ **All patient co-payments and deductibles, as required by your specific insurance coverage, are due and payable at the time of EACH VISIT.**
- ❖ **You are responsible for providing us with accurate insurance information at the time of service. Failure to do so could result in your claim being rejected or delayed. Repeated filing of duplicate insurance claims due to inaccurate or inadequate information provided by you may be subject to a re-filing fee of \$10.00 per claim.**
- ❖ **If payment of your claim has not been received within 45 days from the time the claim was filed to your insurance company, you, the patient/responsible party, will be responsible for any unpaid balance.**
- ❖ **If your insurance company pays less than the estimated benefit, you will be responsible for the remaining balance.**
- ❖ **If your insurance company pays more than the estimated benefit, you may have a credit balance on your account. Per your request, you may leave the credit on your account to be applied to charges for future care, or you may request a refund. Foy Dental Care will make every**

effort to process refund requests within 10 business days from the date the request is received.

- ❖ Foy Dental Care will make every effort to minimize bookkeeping errors. In the event that an error should occur, we will do our best to refund any credits as stated above. Should the error result in a debt owed to us, we will provide a correct statement and will allow 45 days for payment to be rendered in full.

PAYMENT AGREEMENT

- ❖ For and in consideration of the provisions of services, I accept the fee charges as lawful debt and promise to pay said fee in full for all services at the time services are rendered.
- ❖ We accept cash, personal check, Mastercard, Visa, American Express, or Discover Card. We do not accept post dated checks.
- ❖ Extended payment plans and interest free financing plans are available through Care Credit and Capitol One.
- ❖ In the event payment is not received by the agreed upon dates, I understand that my account may be subject to a 1 ½% charge (18% APR) and that I may also be responsible for a \$10 monthly rebilling fee.

COLLECTIONS

- ❖ Foy Dental Care reserves the right to assess a service charge of \$30.00 for all returned checks. (or the maximum allowed by law.)
- ❖ Foy Dental Care also reserves the right to forward any and all accounts over 90 days past due to an outside collections agency.
- ❖ I agree to pay any cost accrued in the collection of my account, including the cost of the collection agency fees (33.3% of the overdue balance) reasonable attorney fees and court costs, if such should be necessary.
- ❖ I authorize Foy Dental Care to contact me at any number(s) (including my cell phone) for the purpose of treatment, insurance, or payment for services rendered.
- ❖ I waive all rights of exemption under the Constitution and laws of the State of Alabama.
- ❖ I further authorize Foy Dental Care to receive and exchange credit information.

I hereby authorize release of medical information for insurance claims and payment of my group insurance benefits, otherwise payable to me, to the dentist. I further agree to accept and adhere to the above office policy of Foy Dental Care.

Patient, Parent, or Guardian Signature:

Date:
