OFFICE POLICY
Effective July 1, 2019

Welcome and thank you for choosing Five Star Dentistry, Dr. W. Bryan Boak and Staff. Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. Our primary mission is to deliver the best and most comprehensive dental care available. ***Please review and initial the following***:

1) ***Payment is due in full at the time services are rendered.*** **_____ please initial**

2) Our office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that may apply to the benefits provided. Your dental benefit is a contract between your employer, the patient and insurance company.
It is not a contract between the dentist and the insurance company. **_____ please initial**

3) In the event that you **DO HAVE** dental insurance, my office staff will provide you with the best estimated costs available which we will collect on that date of service. ***THIS IS AN ESTIMATE and not a guarantee of payment by your insurance carrier.*** We will submit to your dental insurance as a courtesy to you at no additional charge. If insurance payment is not received within 90 days, our office will notify you and you will be responsible for outstanding balances. ***Please plan ahead to fully utilize your yearly insurance benefits.*** **_____ please initial**

4) ***Account balances that are past due:*** Collection action may occur should your account become past due beyond 90 days. **_____Please initial**

5) ***If a check or debit transaction is returned or declined for any reason***, there will be a service charge of $35 to cover administration cost levied to us by the bank. **_____ please initial**

6) ***Minor Children – In cases of Divorce or Separation, the parent/legal guardian that accompanies the child is responsible for payment of services.*** *Unaccompanied children will not be seen unless a responsible parent/guardian is with them.* **_____ please initial**

Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patient's financial capabilities. ***Here are the payment arrangements we now offer in our office.***

1. **Cash and Personal Checks** --- Payment in full at the start of treatment ***for the entire treatment plan*** will receive a 5% professional courtesy. **The courtesy does not pertain to credit/debit card/CareCredit transactions or patients who have insurance coverage**.

2. **American Express / Discover / Visa / MasterCard** --- we accept credit cards as payment for treatment as well as Debit Cards.

3. **CareCredit**--- the financing plan ***(subject to credit approval)*** we offer as a separate line of credit to cover you and your family members' healthcare needs. With CareCredit you can enjoy flexible financing options 6, 12 & 18 month interest free financing.

Refunds for Unfinished Treatment: If a patient decides to discontinue treatment after it has been started, **a proportionate refund will be considered but cannot be guaranteed. _____ please initial**

Credits on an Account: If an insurance company pays more than anticipated creating a credit on the account for the patient, we are happy to leave the credit on the account to be applied toward future treatment. Otherwise, a refund back to the insurance company will be issued. All other credits can only be reimbursed in the same format as they were paid. **_____ please initial**

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APPOINTMENTS AND CANCELLATIONS

When we make your appointment, we are reserving office time and resources for our particular needs. We ask that if you must change an appointment, please give us at least **48 hours notice**. This courtesy makes it possible to give your reserved time to another patient who needs the appointment.

_____ **please initial that you have read the cancellation policy**

If at any time you have questions or need explanation of treatment and/or treatment cost, please feel free to address your concerns with the Office Manager. Your cooperation and understanding of the financial policy is most appreciated.

Signature:_____ **Date:**_____